

OSMA Policy Compendium
Policies of the OSMA House of Delegates
Updated October, 2019

Policy D – 1932 – Medical Legislation

1. The OSMA re-emphasizes and re-endorses the established and fundamentally-sound policies of medical organization of Ohio toward all legislation affecting public health, scientific medicine and medical practice, namely:
 - a. The medical profession of Ohio is opposed to the enactment of any legislation which would be detrimental to the health of the citizens of the State or which would hinder or prevent effective public health administration.
 - b. The medical profession of Ohio condemns and opposes those proposals which would interfere with the advancement of scientific medicine; lower the high standards surrounding medical practice in Ohio, and jeopardize the health and welfare of the people by extending legal privileges to unqualified, incompetent and untrained individuals.
2. All OSMA members should take an active, personal interest in molding public opinion in accordance with the foregoing principles, and aid in selecting for public office - national, state and local - persons who can be depended upon to protect and further the best interests of the public generally, and who will look to the medical profession for counsel and advice on those matters pertaining to public health, medical practice and scientific medicine.

Policy 1962 – That a Doctor of Medicine Be Present at All Ohio High School Athletic Body-Contact Contests

1. The OSMA:
 - a. Encourages schools to make arrangements to obtain the services of a physician to counsel coaches and trainers on a continuous basis with regard to the medical aspects of the athletic program and to be available when emergencies arise in any sport.
 - b. Encourages team physicians to avail themselves of the postgraduate medical courses on athletic injuries.

Policy 21 – 1968 – Physician Members on Hospital Governing Boards

1. The OSMA encourages the election and/or appointment of physicians approved by the medical staff, with full voting privileges, to the boards of trustees of hospitals.

Policy 8 – 1973 – Compulsory Formal Postgraduate Education

1. The OSMA is opposed to any discriminatory government rules and regulations regarding compulsory formal post-graduate education and re-examination for re-licensure.
2. The assessment of a physician's competence by his performance is a preferable technique, and as a realistic goal of medicine, should be pursued.

Policy 13 – 1973 – Abortion as a Medical Procedure

1. The House of Delegates of the OSMA adopts as its policy the statement of abortion issued by the OSMA's Committee on Maternal Health, with the exception that abortion upon request, like any other medical procedure, should be performed only in the maternal patient's best interests, and the standards of sound clinical judgment, which together with informed maternal patient consent, should be determinative according to the merits of each individual case.

Statement on Abortion of OSMA Committee on Maternal Health

In view of the recent decision of the United States Supreme Court on abortion the following statement is issued by the OSMA's Committee on Maternal Health.

Abortion shall mean an operation to intentionally terminate a pregnancy with a live or stillborn fetus weighing 500 grams or less, or under 20 completed weeks of gestation. For its performance, adequate facilities, equipment and personnel are required to assure the highest standards of patient care.

First trimester abortions (up to 12 weeks since conception) should be performed in a hospital or in a facility that offers the basic safeguards provided by hospital admission and has immediate hospital back-up. Such a facility should be accredited by the Joint Commission on Accreditation of Hospitals or licensed by the State of Ohio.

Abortions beyond the first trimester should be performed in a hospital.

Facilities for the performance of first trimester abortions should include appropriate surgical, anesthetic and resuscitation equipment. In addition, the following should be provided:

- 1. Verification of the diagnosis and duration of pregnancy.*
- 2. Pre-operative instructions and counseling.*
- 3. Recorded pre-operative history and physical examination, particularly directed to identification of pre-existing or concurrent illnesses or drug sensitivities that may have a bearing on the operative procedures or the anesthesia.*
- 4. Laboratory procedures as usually required for a hospital admission, including blood type and Rh factor.*
- 5. Prevention of Rh sensitization.*
- 6. A receiving facility where the patient may be prepared and receive necessary pre-operative medication and observation prior to the procedure.*
- 7. A recovery facility in which the patient can be observed until she has sufficiently recovered from the procedure and the anesthesia and can be safely discharged by the physician.*
- 8. Post-operative instructions and arrangements for follow-up including family planning advice.*
- 9. Adequate permanent records.*

It is recognized that abortion may be performed at a patient's request or upon a physician's recommendation. No physician should be required to perform, nor should any patient be forced to accept, an abortion.

The usual informed consent, including operative permit, should be obtained. The same indications for consultation should apply to abortions as to other medical-surgical procedures.

Abortions should be performed only by licensed physicians who are qualified to identify and manage those complications that may arise from the procedure.

Policy 16 – 1976 – Official Representative of Organized Medicine

1. The OSMA reaffirms its position that the most effective representation of organized medicine, as well as of the individual physician, is through a strong relationship of the AMA, the State Medical Societies and their component societies.

Policy 34 – 1977 – Contingency Fees

1. The OSMA continues to urge and/or petition the Ohio Supreme Court to apply reasonable limits on contingency fees in all tort actions.

Policy 79 – 1977 – Insurance Coverage for Alcoholism Treatment

1. The OSMA continues to recognize alcoholism as an illness or disease.
2. The OSMA continues to support treatment of alcoholism.
3. The OSMA supports health insurance coverage for treatment alcoholism in whatever setting is most appropriate and cost effective.

Policy 24 – 1978 – Collateral Source

1. The OSMA supports the position that collateral source payments of any kind shall be deducted from any judgment or award and the payer of any collateral source benefits shall not recover the amount of collateral source payment from either the defendant or the defendant's insurer.

Policy 25 – 1978 – Tort Reform

1. The OSMA supports the following:
 - 1) Mandatory notification in writing of all parties of intent to sue at least ninety days prior to the actual filing of a medical liability claim and that such notice would not further toll the statute of limitations set forth in Section 2305.11(A) of the Ohio Revised Code.
 - 2) Actions for malicious prosecution may be predicated upon loss of reputation, legal and other expenses incurred in defending an action brought without reasonable grounds and that it is not necessary that such action deprive the defendant of personal property or liberty as a predicate for an action for malicious prosecution.
 - 3) In any claim or counter-claim by a defendant charging that the original action is one maliciously brought, inquiry into whether there is reasonable cause for the action should include the extent to which the attorney investigated the case.
 - 4) Evidence that an ordinary review of the records and other evidence would have shown that the defendant committed no act or failed to act in such a way as to contribute to the proximate cause of the incident which is the subject of the action, is prima facie evidence of malicious prosecution

Policy 36 – 1978 – Contraceptive and Prenatal Services for Minors/Contraceptive Services for Minors

1. The OSMA supports permitting Ohio physicians, according to their own conscience, to counsel and prescribe methods for contraception to minors, to provide objective pregnancy options counseling to minors, and to provide medical management of pregnancy of minors at the request of the minor (including abortion in compliance with Ohio state law).

Policy 44 – 1978 – Medical Staff Self-Governance

1. The OSMA supports the right of all medical staffs to conduct the practice of medicine in all facilities according to the rules and regulations governing the staffs as set forth in the bylaws and regulations drawn up and approved by both the medical staffs and the governing body of the facilities.
2. The OSMA opposes any unilateral action of hospital boards of trustees that alters or bypasses previously adopted regulations of the medical staff.

Policy 56 – 1978 – Physicians Responding to Emergencies in Hospitals

1. The OSMA supports the Good Samaritan Statute (O.R.C. 2305.23) extending immunity from civil liability to physicians who voluntarily respond to emergency situations in any location provided that the responding physician does not bill for his services.

Policy 17 – 1979 – Consent Calendar

1. The OSMA adopts the House procedure rule called a Consent Calendar for use by its Policy Committees.
2. This Consent Calendar will be placed at the beginning of a Policy Committee Report for approval as a group.
3. Any delegate may request that a policy or policies on the Consent Calendar be removed and be considered separately prior to the vote for the policies on the Consent Calendar.

Policy 21 – 1979 – Reduction of Dues for Physicians in Their First Year of Practice

1. OSMA dues for Active Members will be reduced by 50% for one year for physicians in their first year of practice after training is completed.

Policy 42 – 1979 – Retrospective Review

1. The OSMA opposes retrospective review payment for health care claims.
2. Where retrospective review and denial is presently being carried out by third-party payers, the OSMA supports an appeal mechanism available upon request of physician or patient which is not under the control of the third-party payor and consists of a committee of the physician's peers.

Policy 45 – 1979 – Federal Discrimination against Teaching Hospitals

1. The OSMA opposes differential payment for the services of physicians at teaching hospitals.

Policy 37 – 1980 – Participation in Organized Medicine

1. We preserve the present federation system of County Society, State Association and the AMA, maintaining direct representation from local grass roots to the national forum.
2. Our elected leaders in these organizations will act in ways not only to inspire more participation by their members, but also to encourage nonmembers to be proud to join together in each level of representation.
3. Each of us as individual members of these organizations will undertake a more positive role in encouraging our nonmember peers to join us in the collective effort to preserve the free enterprise, privately responsible practice of medicine.

Policy 45 – 1980 – The Physician's Role in Returning Patients to Their Jobs

1. The OSMA supports patients returning to work at the earliest date compatible with health and safety.

Policy 50 – 1980 – Outpatient Physicians' Service Reimbursement

1. The OSMA supports reimbursing Medicaid outpatient physicians' services at identical rates, whether delivered in an office, ambulatory clinic, HMO, or hospital.

Policy 51 – 1980 – Reaffirmation of Existing Policy

1. The House of Delegates of OSMA allows Policy Committees to submit all policies for reaffirmation of existing policy to the House under a separate category similar to the Consent Calendar and entitled, "Reaffirmation of Existing Policy."

Policy 56 – 1980 – Confidentiality of Physician-Patient Communications

1. Ohio physicians should, in the highest and best tradition of the profession and in accordance with the Ohio law affirming the physician-patient privilege, strictly observe and hold inviolate all communications between them and their patients except in those instances where patients expressly waive the privilege or the privilege is waived by operation of law.

Policy 59 – 1980 – Qualifying Expert Witnesses

1. The OSMA supports mandated expert witness qualifications including educational and professional knowledge as a general foundation for testimony, current personal experience and practical familiarity with the problems that are being considered and be engaged in the practice of the medical subject under discussion.

Policy 29 – 1981 – The Right of a Hospitalized Patient to Choose His/Her Attending or Consulting Physician

1. The OSMA supports the right of a hospitalized patient to choose his/her attending or consulting physician provided that the physician has privileges to practice and is qualified to perform required services in the hospital and is willing to accept the patient.

Policy 51 – 1981 – Policy to Teach Bio-ethics in Ohio Medical Schools

1. The OSMA supports including bio-ethics in the curricula of medical schools in the State of Ohio.

Policy 52 – 1981 – Comprehensive Health Education in Ohio Schools

1. The OSMA supports comprehensive K-12 health education programs.

Policy 9 – 1982 – Parliamentarian

1. The OSMA will provide an accomplished and competent parliamentarian to insure orderly procedure for each session of the House of Delegates.

Policy 21 – 1982 – Assignment of Insurance Benefits

1. The OSMA supports insurance carrier recognition of a valid assignment of benefits to a party who has a legitimate financial interest in a claim and payment to the party directly or list the party as a co-payee on the check or draft.

Policy 24 – 1982 – Medical Staff Representation on the Board of Trustees of a Tax Supported Hospital

1. The OSMA supports full voting membership on the board of trustees of a state or county hospital by a member or members of the medical staff of a hospital funded by state or county taxes.

Policy 25 – 1982 – The American Student in Foreign Medical Schools

1. The OSMA encourages the Ohio Board of Regents to develop standards for the conditions under which students to foreign medical schools function in medical student clinical clerkships offered by hospitals in the State of Ohio, which will be equivalent to those offered by medical schools in the United States, and which will clearly delineate the responsibilities of the supervising physicians for the actions of the student.
2. The OSMA encourages State Medical Boards to develop standards to assure that foreign medical graduates have received a medical school education substantially equivalent to that received in a U.S. medical school prior to their examination for licensure.

Policy 27 – 1982 – Develop Within the MSS Programs Which Would Assist in Improving the Public Health

1. The OSMA encourages medical students and the Medical Student Section to participate in public service activities.

Policy 35 – 1982 – Education Regarding Suicide Recognition, Prevention and Treatment

1. The OSMA encourages physicians to continue their education in the recognition, treatment, and prevention of potential suicides and the management of survivors of suicide attempts.

Policy 6 – 1983 – Workmen's Compensation Disability Determinations

1. The OSMA endorses the concept of consistent and reproducible workers' impairment determinations by mandatory use of the AMA Guides to the Evaluation of Permanent Impairment.

Policy 18 – 1983 – Prescription Abuse

1. The OSMA intensifies its efforts at educating its members regarding prescription abuse, and in the ways in which physicians can reduce the opportunities for misuse of prescriptions.
2. The OSMA continues and increases its cooperation with other agencies and organizations in monitoring prescription abuse, and in developing solutions to the problem of prescription abuse.

Policy 31 – 1983 – Drug Availability

1. Every patient should have available any drug approved by the FDA that his or her physician thinks is needed and helpful.
2. The FDA-approved drugs should be reimbursed by third party payers.

Policy 39 – 1983 – Corporal Punishment in Schools

1. The OSMA supports the abolition of corporal and abusive punishment in schools throughout the State of Ohio with these exceptions: 1) disarming a student; 2) breaking up fighting among students; 3) self-protection of teachers, protection of students, or another teacher.

Policy 41 – 1983 – Boxing as a Health Hazard

1. The OSMA supports the elimination of boxing from amateur, scholastic, intercollegiate and governmental athletic programs as detrimental to the health of participants.

Policy 43 – 1983 – Sexual Harassment

1. The OSMA encourages its members to work toward the eradication of sexual harassment where it exists in their institutions and offices, and in all other workplaces.

Policy 13 – 1984 – Third Party Reimbursement Problems

1. The OSMA opposes any language in third party reimbursement forms and other literature that implies physicians' fees above insurance benefit levels are improper and excessive.

Policy 16 – 1984 – Cognitive Services Reimbursement

1. The OSMA supports the concept that third party payers should provide equitable reimbursement for physician's cognitive services in comparison with their procedural services.

Policy 21 – 1984 – Payment for Physicians' Services

1. Patients maintain the right to assign benefits to their physicians under all health insurance plans.

Policy 36 – 1984 – Physician Criticism of Colleagues

1. The OSMA encourages all physicians to make a sincere and conscientious effort to be constructive and positive in criticism of their peers.

Policy 37 – 1984 – Hospital Ethics Committees

1. The OSMA supports hospital ethics committees, which should include representation from both the medical staff and non-medical fields.

Policy 38 – 1984 – Free Choice of Physician

1. The OSMA encourages public support for health care plans which permit free choice of physician.

Policy 43 – 1984 – Financial Support - Homeless and Chronically Mentally Ill

1. The OSMA supports adequate and appropriate support for the care of chronically mentally ill.

Policy 49 – 1984 – Preference for Hospital Delivery Over Home Births

1. The OSMA encourages its members to educate their patients about the increased risks of home delivery compared to hospital delivery.

Policy 55 – 1984 – ACLS and ATLS Courses for Physicians

1. The OSMA urges that physicians primarily responsible for the care of multiple systems trauma be certified in Advanced Cardiac Life Support (ACLS) and Advanced Trauma Life Support (ATLS).
2. The OSMA urges that certification in advanced Cardiac Life Support (ACLS) and Advanced Trauma Life Support (ATLS) be included in all general surgical and emergency medical residency programs and available in all other residency programs.

Policy 8 – 1985 – Unethical Aspects of Certain Medical Care Plans

1. The OSMA's position is that it is unethical for an attending physician for personal financial gain to withhold appropriate medical care services from his patient and, further, that referral of a patient by an attending physician to a consultant should be based on the consultant's individual competence and ability to perform the services needed by the patient.

Policy 36 – 1985 – Abortion Clinic Violence

1. The OSMA opposes acts of violence against abortion clinics and other health care facilities as a violation of the right to the access of health care.

Policy 42 – 1985 – Eye Prophylaxis in Newborns for Gonorrhea

1. Eye prophylaxis for newborns should be continued in all cases including Caesarean section.

Policy 45 – 1985 – Generic Drugs

1. The OSMA supports the prescribing of generic drugs for their patients whenever it is deemed by a physician that a biologically equivalent generic is available.

Policy 56 – 1985 – Alcohol Impaired Driving

1. The OSMA supports legislation which would require liquor establishments to post information on alcohol toxicity.

Policy 6 – 1986 – Standardization of Preadmission Certificate Criteria

1. The OSMA supports the standardization of administrative procedures for preadmission certification programs, including both the administrative requirements to be met and the forms to be completed.

Policy 8 – 1986 – Physician Reimbursement for Home Health Care

1. The OSMA supports equitable remuneration consistent with services rendered by physicians when treating patients at home.

Policy 9 – 1986 – Quality Assurance

1. Members of quality assurance mechanisms assure that patient care is consistent with accepted standards of medical practice.

Policy 11 – 1986 – Support of Free Choice of Personal Physicians by Participants in Government Programs

1. The OSMA supports the right of freedom of choice of physician for participants in government sponsored health care programs.

Policy 22 – 1986 – Pediatric Emergency Care

1. The OSMA supports training in pediatric advance life support and trauma for all emergency care providers, especially those involved in pre-hospital care.

Policy 32 – 1986 – Foreign Medical Graduates

1. The OSMA supports the rights and privileges of all physicians duly licensed in the State of Ohio regardless of ethnic or educational background.

Policy 45 – 1986 – Eye Safety

1. The OSMA encourages its members to educate their patients to wear safety lenses or goggles while operating equipment in home workshops, for lawn care, hunting or any other activity that may prove hazardous to their eyesight.

Policy 10 – 1987 – Second Opinion Plans

1. The OSMA supports voluntary patient or physician generated second surgical opinion programs.

Policy 35 – 1987 – OSMA Policy on Advertising

1. The OSMA encourages its members who wish to market their services to adopt marketing practices:
 - 1) which are not false, fraudulent, deceptive or misleading; and
 - 2) which are designed to give the public adequate information regarding the nature and scope of the various medical specialties to permit individuals to make informed choices regarding their selection of physicians.

Policy 55 – 1987 – Early Detection of Disease

1. The OSMA supports funding for programs for early detection of life threatening diseases under physician direction, if consistent with current screening criteria guidelines and with adequate follow-up, as procedures important in saving lives and health care dollars.

Policy 32 – 1988 – Young Physicians as Delegates and Alternate Delegates

1. The OSMA urges each of its county medical societies to encourage and select qualified young physicians to serve as delegates or alternate delegates to the OSMA as a means of getting these physicians more involved in the process which will affect their future and the future of all physicians.

Policy 35 – 1988 – Oppose Voluntary Active Euthanasia (Mercy Killing)

1. The OSMA opposes Voluntary Active Euthanasia (mercy killing) as unethical.
2. The OSMA opposes any legislation which would legalize voluntary active euthanasia (mercy killing) and/or legislation requiring a physician to directly or indirectly participate in such action(s).

Policy 37 – 1988 – Infertility Insurance Coverage

1. The OSMA supports health insurance coverage for the diagnosis and treatment of recognized male and female infertility.

Policy 44 – 1988 – Awareness of Participating Providers

1. The OSMA encourages all marketing materials of HMOs, PPOs, and other alternate health care delivery systems clearly state to prospective participants that joining the program may terminate their prior doctor-patient relationship.

Policy 62 – 1988 – Donation of Professional Time to Poor

1. The OSMA commends its members for continuing to donate professional time to serving the poor.

Policy 68 – 1988 – Public Education on Hazards of Tanning Parlors

1. The OSMA endorses the findings released by the FDA warning Americans that the use of UVA tanning booths and sun beds pose potentially significant health risks to users and should be discouraged.

Policy 7 – 1989 – Physician Liability for Managed Health-Care Plans

1. The OSMA opposes clauses in managed health-care plan agreements which require physicians to be held liable for any judgment against the plan arising out of negligence of that plan.

Policy 8 – 1989 – Medicare Terminology

1. The OSMA opposes use of such phrases as "not reasonable and necessary" and "medically unnecessary services" and instead advocates for use of the more appropriate and accurate term "non-covered medical services."

Policy 9 – 1989 – Third-Party Payer Intrusion into Private Practice of Medicine

1. The OSMA opposes interferences by third-party payers in patient-physician relationships.

Policy 16 – 1989 – Medicaid Physician Reimbursement

1. The OSMA encourages the Ohio Department of Human Services to develop realistic and appropriate physician reimbursement for Medicaid services and remove the disincentives evident by the burdensome administrative paperwork required.
2. The OSMA will continue to work to obtain adequate Medicaid funding to ensure patient access and physician reimbursement.

Policy 18 – 1989 – Simplified Correction for Medicare Carrier Secondary Responsibility

1. The OSMA supports a simplified method of claim payment correction when Medicare carriers identify the primary liability of another insurer.
2. This simplified payment correction system eliminates, as much as possible, the involvement of the physician's office and the patient.

Policy 20 – 1989 – Encouragement of OSMAPAC Membership

1. The OSMA encourages all OSMA delegates and alternate delegates to be members of OSMAPAC.

Policy 23 – 1989 – Medical Staff Bylaws and Peer Review

1. The OSMA recommends that all organized medical staffs be governed by medical staff bylaws.
2. The OSMA opposes any action that would impede or deny an organized medical staff's right or ability to be organized and governed by its own medical staff bylaws.
3. The OSMA encourages each hospital medical staff to review its peer review and fair hearing process to ensure a fair procedure and reduce potential liability.

Policy 24 – 1989 – Patient Advocate

1. The OSMA encourages each hospital medical staff to work with its hospital administration to provide a mechanism within the hospital that allows the patient to verbalize concerns through a patient care representative.
2. Any such patient concerns should be reported to the patient's attending physician.

Policy 52 – 1989 – Education Regarding Prescribing Controlled Substances

1. The OSMA in cooperation with appropriate agencies develops and makes available educational programs and information to ensure proper prescribing and dispensing of controlled substances.

Policy 54 – 1989 – Waiting Period before Gun Purchase

1. The OSMA supports a waiting period of at least one week before purchasing any form of firearm in the state of Ohio.

Policy 60 – 1989 – Anabolic Steroids

1. The OSMA opposes prescribing, dispensing or sale of anabolic steroids for improving athletic performance.

Policy 62 – 1989 – Care of the Chronically, Mentally Ill

1. The OSMA encourages improvement of Ohio's mental health system.
2. The Ohio mental health system should provide up-to-date psychiatric treatment to patients with acute and intermittent psychiatric conditions, as well as planning, evaluation and treatment for those with chronic psychiatric conditions.
3. Decisions concerning access to and treatment in the Ohio mental health system should be made by physicians.

Policy 63 – 1989 – Mandatory Random Drug Testing in Competitive Sports

1. The OSMA supports local requirements for mandatory random drug testing as a requirement for participation in scholastic sports in Ohio.

Policy 66 – 1989 – Warning Label on Personal Listening Devices

1. The OSMA supports requiring all manufacturers of personal listening devices with earphone speakers to label their products with "MAY BE DANGEROUS TO YOUR HEARING" in an easily recognizable location.

Policy 6 – 1990 – Tanning Parlors

1. The OSMA continues to support an educational campaign on the hazards of tanning parlors, as well as the development of local tanning parlor ordinances to protect our patients and the general public from improper and dangerous exposure to ultraviolet radiation.
2. The OSMA supports legislation to strengthen state laws to make the consumer as informed and safe as possible.

Policy 10 – 1990 – Policy on Abortion

1. It is the position of the OSMA that the issue of support of or opposition to abortion is a matter for members of the OSMA to decide individually, based on personal values or beliefs.
2. The OSMA shall take no action which may be construed as an attempt to alter or influence the personal views of individual physicians regarding abortion procedures.

Policy 23 – 1990 – Hospital Boards of Trustees

1. The OSMA supports requiring that at least one voting member on a hospital's Board of Trustees be a member of that hospital's medical staff, in active practice at that hospital, and elected by the medical staff.

Policy 43 – 1990 – Prohibiting Therapeutic Substitution in Ohio

1. The OSMA opposes therapeutic substitution (the process by which a pharmacist replaces a drug prescribed for a given patient with a different chemical compound from the same drug category without the prior consent of the prescribing physician).

Policy 54 – 1990 – Raise Revenue for Health-Care Needs

1. The OSMA supports an increase in federal excise taxes for tobacco and alcohol which would be allocated to health-care needs.

Policy 57 – 1990 – Health Promotion and Disease Prevention Education

1. The OSMA supports the implementation of effective health promotion/disease prevention curricula in medical schools, residency programs and CME programs.

Policy 67 – 1990 – Substance Abuse as a Public Health Hazard

1. The OSMA supports prohibition of advertising of tobacco and tobacco products.

Policy 74 – 1990 – Physician Representation on Health-Care Boards and Committees of the State of Ohio

1. The OSMA urges the Ohio General Assembly, the Ohio Department of Health, the Ohio Department of Insurance and other agencies involved in the public health for the state of Ohio to select members of the medical profession for health care-related bodies so as to increase the proportion of physicians in active clinical practice serving on these boards and committees and encourage OSMA physicians to participate on the boards when asked.

Policy 81 – 1990 – Accountability of Third-Party Reviewers

1. The OSMA encourages the Ohio State Medical Board to recognize that those individuals (physicians or non-physicians) making decisions which determine the type and location of testing, procedures, and or admission to the hospital for patients and physicians should be held accountable in the same manner as the patient's treating physician.
2. The OSMA supports legislation that recognizes medical decisions which influence hospital-patient care through pre-certification of testing, procedures, and/or admission to the hospital are the practice of medicine and must be done under the direction and supervision of an Ohio licensed physician.

Policy 82 – 1990 – Third-Party Payers and Patient Care Standards

1. The OSMA advocates that hospital medical staffs have the primary responsibility for establishment and enforcement of all medical quality standards within their institution.

Policy 83 – 1990 – Selection of Medical Staff Officers

1. The OSMA supports requiring that all medical staff bylaws and hospital governing documents recognize the inherent authority of the medical staff to elect the Medical Staff Officers and provide that such elections of officers are not subject to hospital governing body approval, affirmation or concurrence.

Policy 1 – 1991 – Third-Party Reimbursement for Telephone Time

1. The OSMA supports reimbursement to physicians for telephone calls required by third-parties.

Policy 10 – 1991 - Standardized Explanation of Benefits to Patients

1. The OSMA supports a standardized explanation of benefits for patients that includes the following information: 1) day of service; 2) place of service; 3) billing parties; 4) CPT code and description of service.

Policy 19 – 1991 – Quality of Life Issues Considered in Life Prolonging Therapy

1. The OSMA reaffirms the physician's primary role in guiding the patient, family and other members of the health care team to consider both the quality of life, as well as the longevity of life, when making medical treatment decisions.

Policy 34 – 1991 – Child Care in Hospitals

1. The OSMA encourages hospitals to establish child care provisions for hospital personnel and staff physicians.
2. The hours and staffing of child care facilities should take the needs of physicians-in-training and medical students into consideration.

Policy 39 – 1991 – Expert Witness Testimony

1. The OSMA affirms that qualified expert witnesses in medical malpractice actions should devote three-fourths of their professional time to active clinical practice in their field of specialty.

Policy 44 – 1991 – Women in Medicine

1. The House of Delegates recognizes and supports women members of this association in their efforts to participate at the operational levels in the formulation of policy for all OSMA programs and projects.

Policy 53 – 1991 – Prevention of Sexually Transmitted Human Papilloma Virus (HPV) Infections

1. The OSMA supports human papilloma virus infection awareness and prevention.

Policy 61 – 1991 – Infectious Disease Precautions for Cadaver Transport

1. The OSMA supports requiring hospitals and morgues to put an infectious disease warning tag on all bodies determined to have died of a reportable infectious disease, such as TB, syphilis, serum hepatitis, or HIV.

Policy 62 – 1991 – Mandatory Use of Protective Helmets

1. The OSMA, recognizing the loss of useful life and expense of care resulting from head trauma occurring in motorcycle or other unprotected vehicle crashes, supports mandatory use of protective helmets at all times when operating motorcycles, bicycles, ATVs, mopeds and snowmobiles.

Policy 64 – 1991 – Permanent Cosmetic Make-Up

1. The OSMA considers the injection of permanent cosmetic material to be the practice of medicine.

Policy 75 – 1991 – Economic Credentialing

1. The OSMA opposes the use of economic criteria not related to quality to determine an individual physician's qualifications for the granting or renewal of medical staff membership or privileges.

Emergency Policy 3 – 1991 – State Medical Board Investigations

1. The OSMA works to ensure that the rights of the individual physician be protected through "due process" mechanisms and the basic Constitutional rights, to face the accusers in any proceedings affecting the physician's right to practice medicine in the state of Ohio.

Policy 11 – 1992 – Recommended Standards for Private (For-Profit) Quality Review

1. The OSMA supports the principles that private review organizations:
 - 1) Guarantee the authenticity of their data before initiating review.
 - 2) Use review physicians of the same specialty.
 - 3) Have a mechanism to report and correct poor quality data and review.

Policy 12 – 1992 – Peer Review Process

1. The OSMA supports the following peer review processes: a) the peer review process eliminates the punitive aspects of the system except for the most egregious problems; b) all initial peer review decisions should allow for rebuttal and discussion; c) all review criteria including generic quality screens, and directives emanating from the peer review process should be made publicly known and sent to all practitioners of medicine for their review and response; and d) peer review should include a physician advocacy system that will diligently uphold the difference of opinion or philosophy before any assignment of quality points are determined.

Policy 19 – 1992 – Third-Party Payor Denials

1. The OSMA supports that a hospital stay denial by an insurance carrier include the specific date of denial and the medical reasons as to why the stay was denied on that date by the carrier.

Policy 26 – 1992 – Long-Term Prescriptions

1. The OSMA encourages insurance companies and other third-party payers to inform their policyholders, enrollees, or beneficiaries that long-term prescribing may not be appropriate for some medical conditions and is solely at the discretion of the prescribing physician.

Policy 52 – 1992 – Organized Medicine's Role in Health Care Policy

1. The OSMA supports negotiation of reimbursement, review of quality and appropriateness of care, review of the appropriateness of fees, and establishment of overall healthcare budgetary predictability.
2. The OSMA supports a specific exemption from anti-trust action for organized medicine in negotiations regarding fees and peer review.

Policy 28 – 1993 – Testing for Treatable Inborn Errors of Metabolism

1. The OSMA supports the elimination of the religious exemption from testing for treatable inborn errors of metabolism which can result in mental retardation or other disability.

Policy 31 – 1993 – Expert Witness Testimony

1. The OSMA supports the AMA guidelines regarding medical expert testimony by physician witnesses in medical injury actions.
2. The OSMA supports any legislative proposals to strengthen qualifications for expert witnesses in Ohio.

Policy 34 – 1993 – Health-Care Reform II

1. The confidential relationship between the physician and patient must be preserved throughout the quality assurance process.
2. The OSMA supports reform of health care to encourage making utilization review in health care standardized and objective.
3. The OSMA supports efforts to require third parties to publish their criteria for utilization review for hospitals and physicians so that these criteria may be reviewed for their validity and appropriateness not only for utilization review purposes, but also to ensure that they further the goal of quality patient care.
4. The OSMA supports efforts to make the appeals process for denials of payment independent of the payer so that the inherent conflict of interest in the present process would be eliminated and dialogue and cooperation between physicians and payers would be encouraged.

Policy 43 – 1993 – Fee for Service

1. The OSMA affirms fee for service as a model for physician payment.

Policy 57 – 1993 – Preservation of Patient/Physician Relationship and Role of Physician as Patient Advocate

1. The OSMA reaffirms the principles embodied in the Hippocratic Oath and Code of Medical Ethics that the physician sustains his/her role of patient advocate.

Policy 59 – 1993 – Tanning Parlor Education and Regulation Initiative

1. The OSMA shall develop a model public health regulation governing tanning parlors.
2. The OSMA encourages county medical societies to support adoption of a public health regulation governing tanning parlors by the board of health in their county.
3. Local boards of education should be encouraged to include the hazards of exposure to UV light in this comprehensive health education curriculum.

Policy 75 – 1993 – Biomedical Research

1. The OSMA is committed to the humane treatment of animals used in biomedical research and the pursuit of alternative methods of research when appropriate.

Policy 14 – 1994 – Hospice Care

1. The OSMA recognizes the benefits of hospice for persons with life limiting illnesses and their families and encourages physicians to recommend hospice care when appropriate.

Policy 21 – 1994 – Uniform Recognition of CPT Codes by All Carriers

1. The OSMA supports use of CPT codes and appropriate modifiers, as written, if these codes are utilized in accordance with the AMA guidelines for CPT usage.

Policy 30 – 1994 – Increase in Number of Primary Care Physicians

1. The OSMA supports positive incentives such as shifting of more subsidies to primary care medical education programs, increasing reimbursement levels, tax abatements and loan repayment programs to attract greater numbers of primary care and rural physicians.
2. The OSMA discourages the enactment of restrictive measures such as licensure limitations, quotas in medical education programs, or compulsory measures which are intended to influence the numbers of primary care physicians in Ohio.

Policy 41 – 1994 – OSMA Reporting Practices

1. The OSMA provides members of the House of Delegates and separate county societies/districts with a report on actions referred to Council at the previous OSMA meeting 90 days prior to the opening of the House of Delegates.

Policy 43 – 1994 – Ohio State Medical Board

1. The OSMA supports limits on the length of time from citation to disposition by the State Medical Board; such time to be no longer than one (1) year.
2. The OSMA supports limits on public disclosure of allegations until final disposition of the allegations by the State Medical Board.

Policy 48 – 1994 – Preservation of the Physician's Role as Patient Advocate

1. The OSMA supports physician freedom to act as the patient's advocate. The physician must be able to advise his or her patients to seek any potentially meaningful medical treatment, independently of whether the physician will thereby benefit or lose financially.

Policy 63 – 1994 – Health-System Reform

1. The OSMA supports only those proposed changes in our health-care system that are in the best interest of patients and which assure that all Americans continue to receive high quality medical care.
2. The OSMA supports the following principles: (1) All Americans shall have access to health insurance; (2) The right of patients to choose their physician freely; (3) The right of patients and their physicians to make medical decisions.

3. The OSMA supports the elimination of underwriting requirements which interfere with the establishment of small business pools.
4. The OSMA supports the elimination of pre-existing condition exclusions from health insurance contracts.
5. The OSMA supports guaranteed portability of health insurance.
6. The OSMA supports, for the medically indigent, the adoption of health insurance vouchers and/or tax credits as one of the mechanisms of providing them health-care coverage.
7. The OSMA supports both Medical Savings Accounts and Medical IRAs as acceptable methods to fund health care.
8. The OSMA supports legislative health-care plans which include fee-for-service as a method of payment for physician services.
9. The OSMA supports the position that free competition and meaningful medical professional liability reform are the more effective ways to contain health-care costs rather than global budgets and spending caps.

Policy 63 – 1994 was reaffirmed at the 2019 OSMA House of Delegates.

Policy 71 – 1994 – Right to Balance Bill

1. The OSMA works diligently toward insuring that any health-care plan adopted in Ohio, in order to preserve the quality of health care for Ohio citizens, allows physicians who have not contracted to do otherwise, to balance bill their patients for fees and portions of fees not paid by third parties, including government.

Policy 73 – 1994 – Changes in Taxation of Health-Care Premiums So That All Citizens Are Treated Equally

1. The OSMA supports equal tax law treatment of health-care expenses of all workers in the same manner.

Policy 74 – 1994 – Application of Health Plans to Elected Officials/Government Employees

1. Any health-care reform plan which excludes federal, state and local elected officials and federal, state and local employees and retirees is not acceptable to the OSMA.

Policy 76 – 1994 – Status of OMSS Representative of the Organized Medical Staff

1. The OSMA recommends that the organized medical staffs of hospitals in Ohio consider specifying in their bylaws that the hospital medical staff section representative is an elected position with a voting seat on the medical executive committee of that organized medical staff.

Policy 7 – 1995 – Right to Contract

1. The OSMA affirms the right of patients and physicians to contract privately for medical services otherwise 'covered' under Part B on an individual case by case basis, on terms that are mutually agreeable to physician and patient alike, without requiring the patient to completely relinquish all Part B benefits for other medical services.

Policy 13 – 1995 – Privatizing Medicare

1. The OSMA supports privatizing Medicare including the use of the medical savings account.

Policy 14 – 1995 – Privatize Medicaid

1. The OSMA supports privatizing Medicaid including the use of the medical savings accounts. *Reaffirmed in 1996.*

Policy 18 – 1995 – Elimination of Contingency Fee

1. The OSMA opposes financial reimbursement of attorneys being related to the outcome of medical malpractice cases.

Policy 24 – 1995 – Motorcycle Helmets

1. The OSMA supports mandatory safety helmet use by all motorcycle or motorized bicycle drivers and passengers.
2. The OSMA supports legislation to require that all persons under the age of 18 years be required to wear a protective helmet while operating a bicycle anywhere in Ohio.

Policy 26 – 1995 – HIV Testing of Pregnant Women

1. The OSMA recommends routine HIV counseling and testing of pregnant women as a part of pre-natal care.

Policy 28 – 1995 – Physician Office Review by Third-Party Payers

1. The OSMA supports development of standardized criteria to be used in managed care contracts for reviewing physicians' offices and medical records.

Policy 39 – 1995 – Preservation of Association Historical Records, Artifacts and Memorabilia

1. The OSMA encourages all county societies to preserve important historical records in their possession.

Policy 28 – 1996 – Breast Reconstruction Availability

1. The OSMA supports access to breast reconstruction surgery for all women, if they desire it, and that access should be available regardless of timing in relationship to the onset of the deformity or absence of their breast, and that insurance carriers' coverage should not discriminate against the female breast for reconstructive coverage including symmetry operations on the opposite breast.

Policy 41 – 1996 – More Routine HIV Testing

1. The OSMA recommends more routine HIV testing especially young sexually active people.

Policy 11 – 1997 – Osteopathic and Allopathic Relations

1. The OSMA continues to investigate possibilities for increased integration with state and local osteopathic physician organizations and with individual osteopathic physicians with the goal toward developing mutually beneficial relationships to strengthen organized medicine statewide.

Policy 13 – 1997 – OSMA Conflict of Interest Policy

1. The OSMA utilizes a conflict of interest policy that will pertain to all members of OSMA Council, elected officers of OSMA and AMA delegates.
2. The OSMA utilizes an appropriate disclosure of potential conflicts of interest statement to be filed by all members of OSMA Council and candidates for office in the OSMA or AMA delegation.

Policy 26 – 1997 – Needle Electromyography

1. The OSMA's position is that needle electromyography is the practice of medicine.

Policy 28 – 1997 – Mandatory Topic-Specific Continuing Medical Education (CME)

1. The OSMA opposes those portions of proposed legislation that include mandatory topic-specific CME requirements for Ohio physicians.

Policy 38 – 1997 – Opposition to “Gag Rules”

1. The OSMA opposes “gag rules” and financial incentives to physicians to limit access to care.

Policy 48 – 1997 – Support Efforts to Encourage Medical Savings Accounts

1. The OSMA continues to promote medical savings accounts.

Policy 54 – 1997 – Youth Leadership Programs

1. The OSMA encourages physicians to be involved with youth related leadership programs and activities in their communities.

Policy 9 – 1998 – Access and Parity of Mental Health Coverage

1. The OSMA supports access and parity of mental health coverage as reflected in the following statements:
 - 1) Treatment of mental health problems should be integrated as much as possible into other aspects of general healthcare.
 - 2) Primary care physicians should have ongoing consultation available from and efficient referral access to expert mental health providers.
 - 3) Health care coverage plans should include mental health benefits on parity with other general medical conditions for medically necessary treatment performed by accountable clinicians.
 - 4) Health care plans that list providers will also list individual mental health care providers so that referrals can be made as a collaborative effort involving patients, referring physicians and mental health care clinicians.
 - 5) Psychiatrists and non-psychiatrists be appropriately compensated for the psychiatric services they provide.

Policy 11 – 1998 – Prescription Equity for Contraceptives

1. The OSMA supports efforts to ensure that, notwithstanding any provision of law to the contrary, each employer group health policy, contract, plan or agreement issued or renewed in the state of Ohio that provides prescription drug coverage, shall provide coverage for any FDA-approved prescriptive contraceptive drug or device, nor shall they impose any unusual co-payment, charge or waiting requirement for such drug or device.

Policy 12 – 1998 – Transmittal of OSMA Policies to the AMA

1. The Ohio Delegation to the AMA may submit and/or co-sponsor policies to the AMA, with approval of Council, only if the timing reasonably precludes OSMA House of Delegates approval and provided no provision of such policy/policies advocate(s) a position contrary to current OSMA House of Delegates policy. In all instances where such a policy is to be submitted or co-sponsored, that action must be approved by the OSMA Council and reported to the OSMA House of Delegates at the next meeting of the full House.

Policy 13 – 1998 – Sponsorship of AMA Policies

1. The Ohio Delegation to the AMA be entrusted to revise (without change of essential substance) when necessary the policy/policies forwarded to the AMA with the intent of crafting each policy to optimally promote its intent at the AMA.
2. The Ohio Delegation to the AMA, unless specifically instructed otherwise, be permitted to hold, when deemed advisable, a policy until the AMA Interim meeting in order to allow a more thoughtful and appropriate revision and to allow gathering and submission of pertinent supporting documentation.

Policy 34 – 1998 – Educating Students about the Hazards of Tanning

1. The OSMA urges that each county medical society pass a policy to work with the individual school districts and other schools in their county to educate students about the hazards of tanning and how to prevent skin cancer.

Policy 19 – 1999 – Enforce Protection of Physicians Rights to Corrective Action Provided in the Physician Health Plan Partnership Act

1. The OSMA opposes termination without cause when used to circumvent the intent of the Ohio Physician Health Plan Partnership Act with regard to physicians' rights to corrective action.

Policy 30 – 1999 – Educating Students about the Hazards of Tanning

1. The OSMA urges the AMA to develop a nationwide program urging that county medical societies pass policy/policies to work with the various schools in their county to include information in their health curriculum about the hazards of exposure to tanning rays.

Policy 6 – 2000 – Strengthening of OSMAPAC

1. The OSMA encourages OSMAPAC to continue its grassroots political efforts to help those candidates who are philosophically aligned with organized medicine's positions.
2. Members of the OSMA Alliance, OSMA physicians and concerned patients join together to participate in the OSMA's Physician Legislative Action Network (PLAN) program to work to identify those legislators and candidates who support the health and welfare for our patients.
3. The OSMA encourages OSMAPAC to continue to identify key contact physician and alliance members in each district and assist these members in increasing electoral participation and in increasing level of financial political contributions.

Policy 15 – 2000 – Emergency On-Call Payments to Physicians

1. The OSMA reaffirms current policy such that physicians providing care in emergency settings will be appropriately reimbursed by the managed-care organization regardless of the physician's participation status with said managed-care organization.
2. The OSMA supports appropriate reimbursement for follow-up care by the initial treating physician for an appropriate time after the initial care, if the patient so desires.

Policy 16 – 2000 – Opposition to Mandatory Pill Splitting

1. The OSMA opposes mandatory policies requiring patients to cut or break pills.

Policy 25 – 2000 – Promote and Expand Medical Savings Accounts

1. The OSMA works with the AMA to remove present restrictions that are limiting utilization of Medical Savings Accounts, and promote this form of health insurance.

Policy 27 – 2000 – Improving Transfer of Patient Care

1. The OSMA supports physician-to-physician communication prior to patient transfer from one health care institution to another, including skilled nursing facilities.

Policy 29 – 2000 – Education to Prevent Teenage Pregnancy and Sexually Transmissible Diseases

1. The OSMA adopts as policy, AMA policy H-170.968 Sexuality Education, Sexual Violence Prevention, Abstinence and Distribution of Condoms in Schools, which states that the AMA supports responsible sex education which includes: information on reproductive biology, accurate and understandable information on sexual abstinence, sexual responsibility,

availability and reliability of contraceptives including condoms, alternatives in birth control, and other information aimed at prevention of pregnancy and sexual transmission of diseases.

Policy 40 – 2000 – Payment for All Procedures Performed During a Single Patient Session

1. The OSMA supports payment for each distinct service provided during a single patient session.

Policy 52 – 2000 – Tax Relief for Health Insurance

1. The OSMA and AMA support 100% tax relief for health insurance.

Policy 7 – 2001 – Support of Four Principles of Hand Awareness

1. The OSMA endorses the Four Principles of Hand Awareness: (1) Wash your hands when they are dirty and before eating, (2) Do not cough into your hands, (3) Do not sneeze into your hands, and (4) Above all, do not put your fingers into your eyes, nose or mouth.

Policy 12 – 2001 – Forced Exclusive Physician Contracting

1. The OSMA opposes the practice of forced exclusive physician contracts.

Policy 22 – 2001 – Neutrality Regarding Emergency Contraceptive Pill

1. The OSMA is neutral in regard to emergency contraception pills.

Policy 12 – 2002 – Emergency Contraception

1. The OSMA encourages hospitals to assure that sexual assault victims are informed about the availability and effectiveness of emergency contraception.

Policy 13 – 2002 – Maintain Privacy of Unfiled Lawsuits

1. The OSMA opposes the collection and use of information concerning threatened and unfiled malpractice complaints about physicians by health insurance companies for credentialing purposes.

Policy 17 – 2002 – Insurance Cards to Clearly Identify Co-Pays and Yearly Deductibles

1. The OSMA advocates that all third-party insurance identification cards display effective dates, the patient's co-pay for medical services, capitation status, and the annual deductible amounts.

Policy 30 – 2004 – Physician-Owned Health Care Facilities

1. The OSMA supports the concept of physician-owned health care facilities.

Policy 31 – 2004 – Oppose Economic Credentialing

1. The OSMA opposes the use of economic criteria by hospital boards and healthcare delivery systems in the granting of hospital medical staff membership and privileges for licensed physicians to practice medicine.

Policy 2 – 2005 – Federal Medical Liability and Patient Safety Reform

1. The OSMA supports federal medical liability reform, as well as AMA federal patient safety initiatives.

Policy 3 – 2005 – Health Care Costs

1. The OSMA continues to work with the AMA to identify and promote policies and encourage individual ownership of health insurance, including exploring the feasibility of income-based refundable federal and state tax credits to encourage Ohioans to purchase health insurance.
2. The OSMA works to identify and enact changes in Ohio law that would provide for the favorable treatment of Health Savings Accounts.
3. The OSMA works to ensure that any proposal designed to provide patients with health care quality and cost information pertaining to individual physicians, physician group practices, or hospitals includes data that is standardized, accurate, complete, easily understandable and appropriately risk adjusted.
4. The OSMA asks the AMA to work with the American Hospital Association and other interested parties to develop national standards for public reporting of health care quality and cost data pertaining to individual physicians, physician group practices, and hospitals.
5. The OSMA monitors any legislation designed to increase access to health insurance coverage and promote patient choice.

Policy 4 – 2005 – Quality of Care Criteria and Its Measurement by Physicians

1. The quality of care criteria appropriate for disease management should be determined by physicians utilizing relevant specialty organization guidelines.
2. Physicians are encouraged to participate in the development and standardization of information systems enabling the collection of data that will define, measure, and demonstrate the quality of care.
3. The OSMA and third party payers recognize the financial burden of physician implementation of information systems and seek solutions to alleviate this financial burden.
4. The OSMA will provide a periodic overview of available technologies enabling physicians to define, measure, and demonstrate the provision of quality care.
5. The OSMA encourages insurers as they evaluate reimbursement to utilize quality-of-care information supplied by physicians.

Policy 8 – 2005 – Minor Statute of Repose

1. The OSMA supports a legislative effort to enact an Ohio “Minor statute of repose.”

Policy 1 – 2006 – Practice Economics

1. The OSMA shall provide trusted practice management related information, education, resources, products and services to the appropriate segments of its members.

Policy 2 – 2006 – Quality Improvement and Pay-For-Performance

1. The OSMA encourages Ohio physicians to be involved in quality improvement programs in the delivery of healthcare to their patients.

Policy 14 – 2006 – OSMA Support for Legislation to Improve Ohio’s Homestead Exemption Provision

1. The OSMA supports changes to improve Ohio's homestead exemption provision to allow for a reasonable measure of asset protection in the event of a liability judgment.

Policy 15 – 2006 – Health Insurer Interference with Practice Advisors

1. The OSMA opposes efforts by any entity to interfere with or limit the ability of physicians to obtain independent professional advice, from business advisors, accountants, attorneys, or others, related to contracts with health-insurance payors.

Policy 16 – 2006 – Professional Liability Carrier Anti-Competitive Practices

1. The OSMA shall work with the Ohio Department of Insurance to ensure appropriate transparency of claims data between a PLI carrier and its insured.

Policy 1 – 2007 – Collaborating on Health Information Technology Adoption and Exchange

1. The OSMA shall participate in statewide stakeholder efforts to advance health information technology adoption and health information exchange including working with the public and private sectors to seek funding for such projects.
2. The OSMA shall work with physicians, hospitals and other relevant entities to promote mechanisms to share electronic medical records between providers at multiple health care entities.

Policy 5 – 2007 – Patient Choice of Physician

1. The OSMA reaffirms a physician's responsibility to discuss the patient's preference with the patient before a referral is made.

Policy 7 – 2007 – Health Insurer Collection and Dissemination of Information about Physicians

1. The OSMA shall work to ensure that any information about physicians disseminated to the public be collected using transparent methodology and be accurate and complete.
2. The OSMA shall monitor and take appropriate action regarding any insurer's effort to gather, analyze and distribute physician specific performance, compliance or quality information that is used primarily for the financial gain of the insurer.
3. Any effort undertaken by any entity, to collect, analyze, and distribute to consumers information about the quality and efficiency of care provided by Ohio physicians must include a process by which, before the distribution of information to consumers, physicians have the opportunity to review the information for accuracy and validity.

Amend Policy 8 – 2007 – Health Insurer Interference with Physicians' Independent Medical Judgment

1. The OSMA opposes health insurers' interference, either directly or through the use of financial incentives, with the independent judgment of physicians regarding the best interests of patients.

Policy 11 – 2007 – Compounding Pharmacies and "Bioidentical" Hormone Therapy

1. The OSMA adopts existing AMA policy on bioidentical hormone therapy (D-120.969).

Policy 17 – 2007 – Physician and Medical Student Involvement in Public Health Preparedness and Disaster Response

1. The OSMA supports physician and medical student training, participation, and education in public health preparedness and disaster response.

Policy 19 – 2007 – State Medical Board Oversight

1. The OSMA 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.

Policy 20 – 2007 – Stem Cell Research

1. The OSMA adopts the AMA policy regarding stem cell research.

Policy 29 – 2007 – Medicare Reimbursement for Ambulatory Surgery Centers

1. The OSMA opposes preferential reimbursement patterns for hospitals versus ambulatory surgery centers.
2. The OSMA adopts AMA policies H-330.925 and H-70.991.

Policy 1 – 2008 – OSMA Strategy for Unfair Reimbursement Tactics by Health Insurers

1. The OSMA shall use appropriate channels to educate the public about the unreasonable practices of insurance companies including how these practices that affect patient access to care and potentially the quality of care they receive.

Policy 5 – 2008 – Health Insurance Coverage for All Ohioans

1. The OSMA supports guaranteed access to individually owned, affordable and sustainable health care insurance for all Ohio citizens.

Policy 8 – 2008 - Making Third-Party Payer-Driven Treatment Changes Illegal

1. The OSMA opposes coverage denials and pre-certification requirements for patients with chronic illnesses who have been successfully maintained on treatment regimens and to prohibit reversal by third-party payers of approved treatment regimens.
2. The OSMA reaffirms the principle that all changes in treatment plans for patients in Ohio should be driven by the patient's treating physician's sound medical reasoning and not by health insurance third-party payers for non-therapeutic reasons.

Policy 17 – 2008 – OARRS (Ohio Automated Rx Reporting System)

1. The OSMA shall work with the Ohio State Board of Pharmacy to further enhance and simplify OARRS (Ohio Automated Rx Reporting System) for the benefit of our physicians and patients.
2. The OSMA supports ongoing state funding for OARRS (Ohio Automated Rx Reporting System).

Policy 19 – 2008 – Opposing State of Ohio Restrictions of Physician Investment

1. The OSMA opposes any inappropriate state of Ohio proposed limitations on the ability of physicians to participate in or have ownership in ancillary services such as radiology (MRI, X-ray, CT, US), physical therapy, ambulatory surgery centers or hospitals which would be more restrictive than federal government limitations on physician investment.

Policy 36 – 2008 – Third-Party Coding Audits

1. The OSMA advocates that third-party payers be required to reimburse involved physicians for their reasonable audit-related expenses, including for their time, if the physicians' coding was found to be reasonably consistent with current widely accepted standards.
2. The OSMA advocates that third-party payers be required to reimburse involved physicians if the audit demonstrates undercoding.
3. The OSMA advocates that third-party payers' staff be required to provide adequate assistance during the audit process.
4. The OSMA advocates that third-party payers be limited to record review within the previous twelve (12) months.
5. The OSMA advocates that third-party payers be required to provide sixty days for involved physicians to respond to the audit process without penalty.

Policy 41 – 2008 – Childhood Obesity and Nutrition in the Schools

1. The OSMA recommends that our members advocate that their local schools remove soft drinks and candy from vending machines.
2. The OSMA recommends that our members be involved in advocating for healthy nutrition in their local schools.

Policy 42 – 2008 – Reform of Medicaid Managed Care

1. The OSMA continues to work with the State of Ohio to reform the current Medicaid managed care system to make it easier for Ohio physicians to care for this group of patients.

Emergency Policy 1 – 2008 – Ohio Tobacco Use Prevention

1. The OSMA supports ongoing efforts to reduce tobacco use among Ohioans.

Policy 3 – 2009 – Medicaid Managed Care as a Secondary Payer

1. The OSMA works with the Ohio Department of Insurance and Ohio Medicaid to ensure that if Medicaid does, in specific circumstances function as a secondary insurance, physicians who provide services to these individuals are compensated by Medicaid to the full amount of the co-pay and deductible as defined by the primary insurance.

Policy 7 – 2009 – Medicaid Reform

1. The OSMA shall work to get one set of rules for the Medicaid system.
2. The OSMA shall work to be sure that patients who are on an approved drug in one program and are switched to another program may continue the drug without another prior authorization from the physician's office (thus requiring communication between managed care programs when a patient moves from one to another).
3. The OSMA shall work to eliminate current barriers to traditional referral patterns for complicated patients who need a tertiary center regardless of which provider group they are in.
4. The OSMA shall work to eliminate needless hassles for physicians in their offices in obtaining prior authorization for medications and testing.
5. The OSMA shall encourage a statewide source of up-to-date verification of a patient's coverage.

Policy 12 – 2009 – Organized Medical Staff Section and OSMA Annual Meeting Educational Programs

1. The Organized Medical Staff Section (OMSS) CME program shall be integrated into the OSMA educational symposium schedule to support increased membership and participation in the OSMA educational symposium.

Policy 21 – 2009 – Medical Expense Tax Deduction

1. The OSMA supports changes in the federal tax code to reduce the threshold of tax deductibility of patient out-of-pocket medical expenses to 2% of adjusted gross income.

Policy 11 – 2010 – Promoting Free Market-Based Solutions to Health Care Reform

1. The OSMA promotes free market based solutions to improve access and cost effectiveness of health care delivery in the United States.

Policy 12 – 2010 – Response to Patient Protection and Affordable Care Act

1. The OSMA advocates that the state of Ohio take action to modify the Patient Protection and Affordable Care Act with legislation, regulation and/or judicial action that is financially responsible and consistent with AMA policy.
2. The OSMA advocates that our AMA take action to modify the Patient Protection and Affordable Care Act with legislation, regulation and/or judicial action that is financially responsible and consistent with AMA policy.

Policy 13 – 2010 – Federal Health Care Coverage to Include Member of Congress and Their Families

1. The OSMA and the AMA encourage congress and their staffs and families, as fellow Americans, to include without exception their own health care coverage options in any proposed healthcare legislation.

Policy 15 – 2010 – Support for Physicians to Submit Claims and Prescribe by Any Medium

1. The OSMA supports the physician's ability to submit claims directly to payers, by mailing paper claims.
2. The OSMA opposes payers mandating physicians bear the costs associated with payer sponsored clearinghouses or intermediaries.
3. The OSMA supports physicians' ability to continue prescribing via paper or phone, without being subjected to mandatory e-prescribing.

Policy 17 – 2010 – Universal Real-Time Insurance Coverage Verification for Ohio

1. The OSMA shall work with the Ohio Department of Insurance and the Ohio Department of Job and Family Services to require all Ohio Medicaid and private insurers to utilize one of the universal on-line real-time coverage eligibility clearinghouses.

Policy 19 – 2010 – Lifting the Restrictions on Balance Billing

1. The OSMA supports repeal of regulations currently in place that prohibit balance billing for physicians.

Policy 21 – 2010 – Legislation to Change 48-Hour Signature Rule

1. The OSMA shall work with the AMA's model state legislation, the Ohio Hospital Association and the Ohio legislature to change the time frame for the 48-hour signature for verbal and telephone orders to a longer time period, preferably 30 days.

Policy 24 – 2010 – Updating of the Safe Drinking Water Act

1. The OSMA shall petition the appropriate state agencies to identify those local water utilities at risk and to take appropriate steps to assure safe drinking water.

Policy 24 – 2010 was reaffirmed at the 2019 OSMA House of Delegates.

Policy 25 – 2010 – Preparing Students for Medical Practice

1. The OSMA shall encourage pre-medical advisors and organizations to educate pre-medical students about both the realistic challenges and rewards of being a physician.

Policy 03 – 2011 – Legislation to Compel Health Insurance Companies to Approve Dispensing Medically Appropriate Quantities of Formulary Medications

1. The OSMA encourages the development and support of state legislation to require health insurance companies offering pharmacy benefits to cover medication on their formulary at the dose prescribed by an appropriately licensed clinician at a quantity deemed medically appropriate.
2. Ohio legislation shall not permit health insurance companies to bill policyholders more than a single co-pay per month for the same medication, dose, and strength prescribed for that 30-day period by their clinician.
3. The OSMA requests that our AMA work with other state medical societies and with national health insurance companies to approve dispensing medically appropriate quantities of formulary medications.

Policy 04 – 2011 – Evaluation of the Expanding Scope of Pharmacists' Practice and Interference of Pharmacy Benefit Managers in the Practice of Medicine

1. The OSMA shall evaluate and develop new policy addressing the expanding scope of practice of pharmacists in the practice of medicine.
2. The OSMA shall evaluate and develop policy addressing the interference of pharmacy benefit managers in the practice of medicine.

Policy 05 – 2011 – Universal Health Insurance Coverage

1. The OSMA reaffirms support for universal health insurance access for all Americans through market based initiatives to create incentives for the purchase of coverage.
2. OSMA and AMA will pursue legislative and regulatory reform to achieve universal health insurance access through free market solutions.

Policy 10 – 2011 – Standardize Insurance Payment Policies

1. The OSMA supports a requirement that all private insurers standardize their payment policies to accept claims for at least one year after date of service and that private insurers limit their ability to retroactively require provider reimbursement for rejected claims to 6 months or less.

Policy 16 – 2011 – Sexually Transmitted Infections (STI) Education and Prevention Initiative

1. The OSMA requests that the AMA and other appropriate organizations promote a campaign or campaigns to educate the public about the adverse effects of high risk sexual behavior.

Policy 17 – 2011 – Creation of a Legislative and Advocacy Program for Medical Students

1. The OSMA shall develop and implement a Legislation and Advocacy Program that allows medical students to learn about and work in areas such as health care law reform and legislation, legislative process and professional advocacy on the state level.
2. The OSMA shall advertise and offer this program to Medical Students that are matriculated at medical schools in the State of Ohio.

Policy 05 – 2012 – AMA’s Truth in Advertising Campaign

1. The OSMA shall work to enact state legislation to help provide clarity and transparency for patients when they seek out and go to a health care practitioner and that the legislation includes provisions similar to those included in the AMA’s Truth in Advertising campaign.

Policy 07 – 2012 – Limiting Medical Liability Hedge Funds

1. The OSMA opposes medical liability hedge funds and other attempts at third-party financing of medical liability lawsuits.

Policy 12 – 2012 – Pharmacy Scope of Practice

1. The OSMA shall work with the Ohio State Board of Pharmacy to require that a disclosure be made to the prescribing physician and to the patient if a medication is changed from what is ordered by the physician and how it differs, if it is not a generic equivalent.

Policy 13 – 2012 – 48-Hour Rule after Consent to Withhold or Withdraw Life Sustaining Treatment from Patient

1. The OSMA shall seek to amend ORC 2133.08 to allow immediate withholding and withdrawal of life support measures from the critically ill ICU patient that cannot benefit from continued life support measures, providing that the top two applicable priority groups (as defined in ORC 2133.08 (A)(2)) are in full agreement with the decision by the top priority group to withhold and withdraw life support measures.

Policy 14 – 2012 – Addressing Safety and Regulation in Medical Spas

1. The OSMA supports regulation to ensure that cosmetic medical procedures, whether performed in medical spas or in more traditional medical settings, have the same safeguards as “medically necessary” procedures, including those which require appropriate training, supervision and oversight.
2. The OSMA advocates that cosmetic medical procedures, such as botulinum toxin injections, dermal filler injections, and laser and intense pulsed light procedures, be considered the practice of medicine.
3. OSMA continues to evaluate the evolving issues related to medical spas in conjunction with the interested medical specialty societies.

Policy 16 – 2012 – Maintenance of Board Certification and Maintenance of Licensure Requirements

1. The OSMA opposes any efforts by the State Medical Board of Ohio to implement different maintenance of licensure requirements other than those currently in place for physicians in Ohio.

Policy 18 – 2012 – Criminalization of Medical Care

1. The OSMA oppose any portion of proposed legislation that criminalizes clinical practice that is the standard of care.

Policy 20 – 2012 – Physician Reimbursement for Coordination of Care in Medical Home

1. The OSMA shall work with Ohio insurers and the Ohio Department of Insurance to assure that physicians receive adequate reimbursement for providing coordination of care outside of the traditional patient office visit required for the successful treatment of patients in the medical home.

Policy 23 – 2012 – Mandatory Competency Exams for Older Physicians

1. The OSMA opposes mandatory medical competency exams solely on the basis of age.

Policy 27 – 2012 – Transparency in Insurance Coverage Information

1. The OSMA shall work with the Ohio Department of Insurance to develop transparency in the Insurance Card information presented by patients so that physicians are aware of the coverage provided by the insurance program including the patient's responsibility.

Policy 29 – 2012 – Denial of Care by Medicaid Managed Care Programs

1. The OSMA opposes any Medicaid payer's action of requesting proof of qualifications from physicians who have already been credentialed in the program as specialists.
2. The OSMA shall continue to work with all Medicaid entities to decrease the administrative burden for physicians who agree to care for Medicaid patients.

Policy 31 – 2012 – Third Party Carriers Should Include Incentives for Patient Accountability

1. The OSMA supports efforts to encourage third party insurance carriers to include incentives for patient accountability to reduce obesity, tobacco use, physical inactivity and other behaviors contributing to excessive morbidity, mortality and health care costs.

Policy 32 – 2012 – Personal Health Care Record

1. Any proposed solution for health care includes a system to transfer data seamlessly between providers.
2. The OSMA support personal access to one's medical record.

Policy 06 – 2013 – Crafting Innovative Ways of Funding Graduate Medical Education

1. The OSMA supports 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.

Policy 07 – 2013 – Support for Physician led Patient-Centered Medical Home

1. The OSMA 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.

Policy 08 – 2013 – Support for More Primary Care Physicians

1. The OSMA shall 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.

Policy 09 – 2013 – Abolishing Loss of Chance

1. The OSMA shall make every effort to advocate to the Ohio General Assembly to abolish the “Loss of Chance” doctrine.

Policy 11 – 2013 – Oppose the Criminalization of Medical Statements

1. The OSMA opposes the criminalization of mistakes made by physicians in medical records, operative notes, and coding in the absence of any proven billing fraud.

Policy 12 – 2013 – Advocating for Public Education for the Use of Appropriate Health Care Resources

1. The OSMA supports public education initiatives addressing the effective and efficient use of health care resources.

Policy 13 – 2013 – Adolescent Pregnancies

1. The OSMA supports initiatives to reduce the incidence of adolescent pregnancies.

Policy 16 – 2013 – Maintenance of Certification and Licensure vs. Board Certification, Continuing Medical Education and Lifelong Commitment to Learning

1. The OSMA insists that lack of Specialty Board Certification does not restrict the ability of the physician to practice medicine in Ohio.

Policy 33 – 2013 – Patient Steerage by Quality Measures

1. Patient steerage by insurers to lower cost services must be based on established and verifiable national quality measures that are physician developed.
2. The OSMA advocates 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.
3. 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.
4. 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.
5. The OSMA 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.

Policy 34 – 2013 – Patient Satisfaction Surveys Not Valid as Reimbursement Criteria

1. When quality criteria are used as a measure to determine reimbursement for physician services, payers shall only use those quality parameters that are in the direct control of the physician, such as tests or treatment ordered, or appropriate patient education performed.
2. If or when subjective quality criteria are utilized, such as patient satisfaction surveys, such information should be used only as an adjunctive and not a determinative measure of physician quality for the purpose of physician reimbursement.

Policy 36 – 2013 – Peer Review by Specialists with Knowledge of the Situation under Review

1. The OSMA takes 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.
2. The OSMA insists that the review for medical necessity process be timely, courteous, and respectful of the treating physician's work schedule.

Policy 39 – 2013 – Audit Overpayments

1. The OSMA shall work to ensure that insurance companies can only seek reimbursement for medical claims within one year unless fraud or misrepresentation is present.
2. The OSMA shall work to ensure that insurance companies accept claims within one year of provision of service without penalty.
3. When interest is charged to the physician on overpayment of a given claim, the OSMA shall advocate that the physician can charge and be paid an equivalent interest rate on underpayment of claims.
4. The OSMA supports health care providers who have acted in good faith in providing services with a valid contract.

Policy 41 – 2013 – Identifying Chemicals Used by the Oil and Gas Industry as Part of Hydraulic Fracturing

1. The OSMA advocates 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.

Policy 47 – 2013 – Protection of Employed Physicians' Rights

1. 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.

Policy 06 – 2014 – Medicare/Medicaid Reimbursement

1. The OSMA shall adopt a position that non-hospital owned facilities be compensated at parity to hospital-owned facilities for the same services, and that there be no reimbursement inequity based upon facility ownership.

Policy 09 – 2014 – Enforcing State Medical Board of Ohio Transparency

1. The OSMA shall formally request that the State Medical Board Ohio provide a written report and justification for all services mandated in Ohio through the Federation of State Medical Boards.

Policy 10 – 2014 – Repeal the Requirement for Signing a Verbal Admission Order Prior to Discharge

1. The OSMA shall work with the Ohio Hospital Association to educate Ohio's Congressional Delegation regarding this CMS admission order signature rule with a goal of getting the timeframe modified to 30 days.

Policy 11 – 2014 – EMR Vendor Accountability

1. The OSMA shall work with the Ohio Congressional delegation to educate them about physician concerns regarding downtime for the electronic medical record (EMR) and accountability of the EMR vendors for events that occur due to that downtime.

Policy 12 – 2014 – Reimbursement Discrimination for Physician Assistants and Nurse Practitioners

1. The OSMA shall work toward stopping discrimination in payment for services by physician assistants and nurse practitioners by some Ohio Medicaid plans.
2. The OSMA shall work with the Ohio Department of Insurance and Ohio Department of Medicaid to ensure that physician assistants and nurse practitioners are able to practice within their scope of practice and be reimbursed appropriately by all insurers.

Policy 13 – 2014 – Transfer of Records in Retail Settings

1. The OSMA shall work to promote legislation that requires ambulatory clinical care providers and retail clinics to exert a reasonable effort to identify and send a copy of the care record to the patient's primary care physician.

Policy 14 – 2014 – Retail Pharmacy Participation in IMPACT SIIS

1. The OSMA shall work to encourage the retail pharmacies of Ohio to voluntarily participate in IMPACT SIIS for improved continuity of care.

Policy 15 – 2014 – Medication Coverage

1. The OSMA encourages third party payers to provide free real-time electronic information to physicians about medication coverage and required co-pays so that physicians and patients can determine the best medication treatments as appropriate and affordable at the time of service.

Policy 16 – 2014 – Advance Benefits Notification (ABN)

1. The OSMA requests that CMS require the use of a single, standard Advance Benefits Notification (ABN) form for all Medicare beneficiaries including all Medicare Advantage Plans.

Policy 01 – 2015 – Repeal the 2% Medicare Physician Payment Cuts Authorized by Sequestration Action

1. The OSMA shall take all necessary legislative and administrative steps to eliminate the hidden 2% "sequestration" Medicare payment cuts for physicians and the Ohio Delegation to the AMA shall take this policy to the AMA for action at the national level.

Policy 02 – 2015 – Standardizing Physicians' Stance toward Electronic Cigarettes

1. The OSMA supports both a ban on sales of e-cigarettes to minors and a prohibition on the consumption of e-cigarettes by minors.
2. The OSMA supports AMA Policy H-495.973.
3. The OSMA encourages more research into the potential health risks associated with e-cigarettes.

Policy 04 – 2015 – Monitor State Medical Board of Ohio Participation in Federation of State Medical Boards

1. The OSMA shall monitor the State Medical Board of Ohio's membership in the Federation of State Medical Boards (FSMB), and urge withdrawal of the Medical Board's membership and payment of dues to the FSMB immediately should the FSMB require maintenance of certification for physicians in federation states.

Policy 05 – 2015 – Automatic Tracking of Quality Indicators

1. The OSMA urges the Office of the National Coordinator for Health Information Technology to require electronic medical records (EMR) vendors' systems to have the capability to automatically track indicators for the purpose of quality monitoring for all specialties once the data is in the EMR.
2. The Ohio Delegation shall take this policy to the AMA for action at a national level.

Policy 06 – 2015 – Cooperation with Health Information Exchanges

1. The OSMA shall work with the Ohio Legislature and regulatory bodies to remove vendor roadblocks to the exchange of data and require full cooperation of all electronic medical record (EMR) vendors with health information exchanges (HIE) to allow transfer of clinical data between EMR systems.
2. Information technology work/collaboration between the electronic medical record vendor and the health information exchange that is necessary for data exchange shall be at no expense to the provider, practice, or hospital.

Policy 07 – 2015 – Electronic Prescribing of Controlled Substances

1. The OSMA shall work with the Ohio State Board of Pharmacy and other interested parties to facilitate transmission of electronic prescriptions directly to pharmacies for controlled substances.

Policy 08 – 2015 – Revision of HB 341 OARRS Requirements

1. The OSMA fully supports both policies passed by the OSMA Council regarding House Bill 341 of the 130th General Assembly.
2. The OSMA shall work to postpone penalties for not following the statutory and regulatory query requirements from House Bill 341 of the 130th General Assembly.

Policy 11 – 2015 – OSMA Annual Meeting Attendance

1. All members of the OSMA shall be invited to attend each annual meeting.
2. Members of the OSMA shall be seated with, and encouraged to participate in, their residential or practice regional caucus.

Policy 12 – 2015 – OSMA Annual Meeting Costs

1. The OSMA Council shall consider ways of making our House of Delegates meeting more efficient while allowing adequate time for deliberation and debate.
2. The OSMA shall seek a less expensive meeting venue.

3. The meeting venue chosen will be near a group of hotels for those who wish to stay in Columbus the night before or after.

Policy 13 – 2015 – Retiring OSMA Members

1. The OSMA shall create a packet of helpful information and referrals as a resource for retiring members.
2. The OSMA shall create and support a forum for retired members to meet, communicate, and perhaps grow into a meaningful organized group of wise, enthusiastic, resourceful physicians for their own benefit and that of their communities.

Policy 15 – 2015 – Recommendations for Expanded Allergen and Gluten Labeling in Ohio’s Restaurants and Schools

1. The OSMA recommends that Ohio restaurants and schools include allergen and gluten information on menus for each menu item.

Policy 21 – 2015 – Evidence Based Organized Medicine

1. The proposed report from the OSMA Bylaws Task Force and the background material which created the report be part of an ongoing working committee charged with organizational quality improvement. The structure would be a tiered time commitment similar to that of our current nominating committee.
2. This OSMA committee is charged with identifying measures of success by which we can judge the impact of changes.
3. All members of the OSMA shall be invited to attend and participate in House of Delegates deliberations.
4. The OSMA shall proceed with changes to minimize the cost of the OSMA annual House of Delegates meeting.

Policy 22 – 2015 – Representation for Direct OSMA Members

1. Direct members of the OSMA who are not members of a county society shall be invited to attend the geographic District Meeting for either their office or home address and be allowed to vote at that meeting.

Policy 24 – 2015 – Continue OSMA House of Delegates Annual Meeting

1. The OSMA shall continue with an annual meeting including a House of Delegates for policy making with Delegates representing county medical societies and state specialty societies to guide the direction of the organization and establish policy.
2. The OSMA staff shall investigate other venues for the OSMA annual meeting with the goal of decreasing costs.

Policy 26 – 2015 – Delegate Appointments

1. If a county does not appoint a Delegate to the OSMA House of Delegates annual meeting, the District Councilor may appoint a Delegate to represent that county and that Delegate can be a physician who is an OSMA member who lives in that county or a physician who is an OSMA member with a satellite office in that county who regularly sees patients there and is known to the physicians there, but does not live in that county.

Policy 01 – 2016 – Membership List Exchange

1. The OSMA replaces Policy 09 - 2015 and 10 - 2015 (DELETED FROM POLICY COMPENDIUM) with the following: The OSMA and County Medical Societies shall exchange membership lists twice per year on or around March 31 and September 30.

Policy 03 – 2016 – Disclosure to OSMA Members

1. The officers of the OSMA and its executive staff shall make a full report to all OSMA Delegates within 30 days of the conclusion of each annual House of Delegates detailing the real estate transactions, finances and staffing levels of OSMA for the last three years.
2. Delegates are encouraged to share OSMA financial information with OSMA members in their jurisdiction.

Policy 04 – 2016 – OSMA Annual Meeting Schedule

1. The time for the business sessions of the Annual Meeting of the OSMA House of Delegates shall revert to being scheduled to take place on Saturday-Sunday, beginning Saturday morning and carried through as long as necessary on Sunday of the weekend selected for the OSMA Annual Meeting to allow for the appropriate conduct of all business as has historically been scheduled to occur at the OSMA Annual Meeting of the House of Delegates
2. Time will be allotted at the OSMA Annual Meeting for geographic caucus meetings to review the report(s) of the Policy Committee(s) before voting on the items in the report.

Policy 06 – 2016 – OSMA to Financially Support Physical Regional District Meetings in Preparation for OSMA Annual Meeting, OSMA Constitution and Bylaws Amendment – Chapter 4, Section 10

1. OSMA Bylaws Chapter 4, Section 10 be amended as follows:

The House of Delegates shall establish Councilor Districts. The districts shall comprise one (1) or more contiguous counties. A district society may be organized in any of the Councilor Districts to meet at such time or times as such society may fix. The OSMA shall allocate funding for one physical meeting of a council district in preparation for the OSMA annual meeting, if requested by the district councilor.

Policy 07 – 2016 – Cannabinoids

1. The OSMA opposes recreational use of cannabis.
2. The OSMA supports Institutional Review Board (IRB) approved clinical research to explore the potential risks versus benefits of using cannabinoids to treat specific medical conditions.
3. The OSMA supports focused and controlled medical use of pharmaceutical grade cannabinoids for treatment of those conditions which have been evaluated through Institutional Review Board (IRB) approved clinical research studies and have been shown to be efficacious.
4. The OSMA recommends that marijuana's status as a federal Schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines and alternate delivery methods.
5. The OSMA supports limiting cannabinoids prescribing rights, if permitted, to physicians (MDs and DOs).
6. The OSMA opposes legalization of any presently illegal drugs of substance abuse including, but not limited to, cannabis and cocaine, except in the instance of appropriate evidence-based use approved by the FDA.
7. The OSMA encourages physician participation in future legislative and regulatory discussions regarding the legal use of cannabinoids.
8. This policy replaces OSMA Policy 65-1991 (DELETED FROM POLICY COMPENDIUM).

Policy 08 – 2016 – Employed Physicians

1. The OSMA affirms its support for H-225.950 AMA Principles for Physician Employment and will explore state legislation to preserve physician autonomy in the employed setting.
2. The OSMA affirms its support for the principle, as codified in Ohio Revised Code sections 1701.03 (for profit corporations), 1704.04 (limited liability companies), 1785.03 (professional associations) and 4731.31 (rural hospitals), that corporations cannot control the professional clinical judgment exercised within accepted and prevailing standards of practice of a licensed physician in rendering care, treatment, or professional advice to an individual patient.
3. The OSMA will explore legislation or other regulation mandating due process and dispute resolution when a physician is terminated as a result of the physician exercising clinical judgment.
4. The OSMA opposes the use of restrictive covenants in physician contracts that are not consistent with the AMA principles of physician employment agreements.
5. The OSMA shall make the AMA principles of physician employment agreements easily available to all Ohio physicians.

Policy 09 – 2016 – Prior Authorization for Patients Injured at Work

1. The OSMA shall survey physician members who are treating patients with work related conditions to determine the problems associated with obtaining prior authorization for treatment including procedures and medications.
2. The OSMA shall request that the Bureau of Workers Compensation and self-insured employers address the problems associated with obtaining prior authorization for patients injured at work to allow treatment of patients to occur in a timely and appropriate manner.

Policy 10 – 2016 – Preventing Harassment of Physicians

1. The OSMA opposes attempts to deter or intimidate physicians who practice in accordance with their conscience and consistent with the AMA Code of Medical Ethics.

Policy 11 – 2016 – Expansion of U.S. Veterans' Healthcare Choices

1. The OSMA advocates that the Veterans Health Administration expand all eligible health care choices for veterans by permitting veterans to use funds currently spent on them through the VA system, through a mechanism known as premium support, to purchase private health care coverage, and for veterans over age 65, to use these funds to defray the costs of Medicare premiums and supplemental coverage.
2. The OSMA House of Delegates directs the OSMA AMA Delegation to take this policy regarding expansion of health insurance choices for all veterans served by the Veterans Health Administration to our American Medical Association House of Delegates 2016 Annual Meeting with the further request that our AMA support federal legislation to achieve this reform.
3. The OSMA, by means of the OSMA website, as well as written letters to elected federal legislators and the U.S. President, supports federal legislation to achieve reform of veterans' health care choices through premium support to purchase private health care coverage or defray the costs of Medicare premiums and supplemental coverage.

Policy 12 – 2016 – Veterans Health Administration Transparency and Accountability

1. The OSMA advocates that the Veterans Health Administration be required to report publicly on all aspects of its operation, including quality, safety, patient experience, timeliness, and cost effectiveness.

2. The OSMA House of Delegates directs the OSMA AMA Delegation to take this policy regarding Veterans Health Administration Transparency and Accountability to our American Medical Association House of Delegates 2016 Annual meeting with further request that our AMA support federal legislation to achieve this reform.
3. The OSMA, by means of the OSMA website, as well as written letters to elected federal legislators and the U.S. President, supports federal legislation to achieve this reform of Veterans Health Administration transparency and accountability.

Policy 13 – 2016 – Insurance Coverage of Non-Narcotic Treatments Used in Pain Management

1. The OSMA shall work with the insurance companies and the Ohio Department of Insurance to stress the need for the cooperation of the insurance companies in physicians' efforts to treat chronic pain with appropriate medications and all appropriate treatment modalities.
2. The OSMA shall encourage reasonable insurance coverage with affordable patient out-of-pocket costs for non-narcotic treatments that are useful in pain management.
3. The OSMA will support our physician members and stress that the current drug problem is a multifactorial problem not exclusively due to improper prescribing by physicians.

Policy 16 – 2016 – Eliminate the Requirement of “History and Physical Update”

1. The OSMA will work with the Ohio congressional delegation and the American Medical Association (AMA) to:
 - A. Change 42 CFR Section 482.24 (c)(4)(i)(B) to read as follows:

If any changes occur in the patient's medical condition after the medical history and physical examination are completed within 30 days before admission or registration, documentation of an updated examination of the patient must be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.
 - B. Change 42 CFR Section 482.51 (b)(1)(ii) to read as follows:

If any changes occur in the patient's condition, an updated examination of the patient must be completed and documented within 24 hours after admission or registration when the medical history and physical examination are completed within 30 days before admission or registration.
2. The Ohio AMA Delegation will take this policy to the AMA for action at the 2016 Annual Meeting in June.

Policy 17 – 2016 – Ohio Medical Licensure Fees

1. The OSMA shall seek to reduce the cost associated with Ohio physician medical licensure fees.

Policy 18 – 2016 – Site of Service Charges

1. The OSMA requests that the American Medical Association continue to address the current inequity of “site of service” charges being used by hospitals and Medicare.

Policy 19 – 2016 – Weight Loss Medications - Phentermine

1. The OSMA shall request that the State Medical Board of Ohio review Ohio Administrative Code Rule 4731-11-04 in order to update and simplify the process of prescribing weight loss medications.

2. The OSMA advocates that the 12-week limitation for prescriptions of phentermine be modified to allow for prescription by qualified physicians for the time necessary to treat the chronic medical condition of obesity.

Policy 20 – 2016 – Improving Outcomes of Law Enforcement Responses to Mental Health Crisis through the Crisis Intervention Team Model

1. The OSMA supports continued research into the public health benefits of CIT law enforcement training.
2. The OSMA encourages physicians, physician practices, allied healthcare professionals, and medical communities to collaborate with law enforcement training programs in order to improve the outcomes of police interventions in mental health crises.
3. The OSMA supports the use of public funds to facilitate CIT training for all interested members of police departments.

Policy 21 – 2016 – Addressing Food and Housing Insecurity for Patients

1. The OSMA shall recognize food and housing insecurity as a predictor of health outcomes.
2. The OSMA shall encourage the use of housing and food insecurity screening tools by physicians and healthcare staff, similar to the depression screening tools, and assist physicians in identifying appropriate resources and avenues of referral.

Policy 22 – 2016 – Lesbian Gay Bisexual Transgender Queer (LGBTQ) Protection Laws

1. The OSMA supports the protection of Lesbian Gay Bisexual Transgender Queer (LGBTQ) individuals from discriminating practices and harassment.
2. The OSMA advocates for equal rights protections to all patient populations.

Policy 23 – 2016 – Expanding Gender Identity Options on Physician Intake Forms

1. The OSMA supports non-mandatory patient intake forms that allows for sex (assigned at birth) and gender identification that are more inclusive than the binary male/female traditionally asked.

Policy 24 – 2016 – Lifting Restrictions on Federally Funded Firearms Research

1. The OSMA recognizes firearms violence as a public health concern.
2. The OSMA asks the AMA to support the removal of the current restrictions on use of federal funds in researching firearms safety, injury and violence.

Policy 25 – 2016 – Access to Care for Medicaid and Medicaid Product Insured Patients in Ohio

1. The OSMA advocates that Ohio Medicaid and Medicaid product insurers extend coverage to their patients for thirty days beyond the date of non-coverage and reimburse physicians who provide services during this time period.

Policy 26 – 2016 – AMA to Ensure Adequate and Reasonably-Priced Generic Drugs

1. The OSMA requests that the American Medical Association consider all options for reasonably priced generic drugs

Policy 01 – 2017 – Supporting Changes in Health Care Policy that Increase Coverage and Expand Benefits

1. The OSMA supports the elimination of pre-existing condition exclusions from health insurance contracts and supports providing all Ohio citizens with high quality health care.
2. The OSMA opposes changes to healthcare policy that would decrease access to health care coverage for the citizens of Ohio.
3. The OSMA supports the inclusion of young adults up to age 26 on their parents'/guardians' health care plans.
4. The OSMA supports health care policies that allow states and institutions the right to explore and develop individualized models for covering the uninsured.

Policy 01 – 2017 was reaffirmed at the 2019 OSMA House of Delegates.

Policy 02 – 2017 – Discriminatory Screening of Potential Patients

1. The OSMA HOD directs the AMA Delegation to request that the AMA Council on Ethical and Judicial Affairs give an ethical opinion on discriminatory pre-screening tools before physicians accept patients in their practice.

Policy 03 – 2017 – Expansion of U.S. Veterans' Healthcare Choices

1. The OSMA House of Delegates directs the OSMA American Medical Association (AMA) Delegation to carry a resolution to our AMA House of Delegates 2017 Annual Meeting requesting that our AMA adopt as policy that the Veterans Health Administration expand all eligible veterans' health care choices by permitting them to use funds currently spent on them through the VA system, through mechanisms such as premium support, to purchase private health care coverage, and for veterans over age 65 to use these funds to defray the costs of Medicare premiums and supplemental coverage.
2. The OSMA House of Delegates directs the OSMA AMA Delegation to carry to our AMA House of Delegates 2017 Annual Meeting a resolution further requesting that our AMA actively support federal legislation to achieve this expansion of healthcare choices for Veterans Administration eligible veterans.
3. The OSMA by means of the OSMA website, as well as written letters to elected federal legislators and the U.S. President, again actively support federal legislation to achieve this reform of veterans' health care choices.

Policy 04 – 2017 – Department of Veterans Affairs Accountability and Whistleblower Protection

1. The OSMA advocates for the existing AMA policy (H-435.942) concerning whistleblower protections for health care professionals and other parties, including those employed within the VA system.

Policy 05 – 2017 – Veterans Health Administration Transparency and Accountability

1. The OSMA House of Delegates directs the OSMA AMA Delegation to carry a resolution to our American Medical Association House of Delegates 2017 Annual Meeting requesting that our AMA adopt as policy that the Veterans Health Administration be required to report publicly on all pertinent aspects of its operation, including quality, safety, patient experience, timeliness, and cost effectiveness.
2. The OSMA House of Delegates directs the OSMA Delegation to carry to our AMA House of Delegates 2017 Annual Meeting a resolution further requesting that our AMA actively support federal legislation to achieve this reform of Veterans Health Administration transparency and accountability.
3. The OSMA, by means of the OSMA website, as well as written letters to elected federal legislators and the U.S. President, actively supports federal legislation to achieve this reform of Veterans Health Administration transparency and accountability.

Policy 06 – 2017 – Direct American Medical Association to Ask CMS and HHS to Remove Practice Expense and Malpractice Expense from Publicly Reported Payments

1. The OSMA ask its AMA Delegation to ask the AMA House of Delegates to petition CMS and the office of Health & Human Services to remove practice expense and malpractice expense from reimbursements reported to the public.

Policy 07 – 2017 – Improving Clinical Utility of Medical Documentation

1. The OSMA AMA Delegation asks the AMA to advocate for appropriate, effective, and less burdensome requirements in the use of electronic health records.

Policy 08 – 2017 – Medicaid Payment to Physicians for Dual Eligible Patients

1. The OSMA advocates for payment to physicians by Ohio Medicaid of the balance between the payment by Medicare and the allowed Medicare amount for dual eligible patents to ensure adequate health care.

Policy 09 – 2017 – Change OARRS requirements for Medications Which Can Be Prescribed with Refills for 6 Months

1. The OSMA shall work on decreasing the requirement for physicians to check OARRS every 90 days to every 6 months for benzodiazepines.

Policy 11 – 2017 – Third Party Patient Reimbursement for Out-of-Network Physicians

1. The OSMA adopts a policy and provides support to physicians and patients which requires insurers and third-party payors to properly reimburse patients and/or out-of-network physicians their usual charges, and that there be no increase in deductibles or co-payments for those patients requiring care from out-of-network physicians because of urgent and emergent treatment needed in emergency rooms and hospitals.
2. The OSMA adopts a policy which requires insurers and third-party payors to reimburse patients and/or out-of-network physicians their usual charges in non-emergent care, if insurer and third-party payor are not able to arrange participating network physician care in a reasonable time, and that there be no increase in deductible or co-payments for those patients.
3. The OSMA directs the AMA Delegation to carry a request to our AMA to adopt a policy which requires insurers and third-party payors to properly reimburse patients and/or out-of-network physicians their usual charges, and that there be no increase in deductibles or co-payments for those patients requiring care from out-of-network physicians because of urgent and emergent treatment needed in emergency rooms and hospitals and/or seek federal legislation addressing these issues.

Policy 12 – 2017 – Medical Price Transparency

1. The OSMA supports legislative efforts to develop medical price transparency which are congruent with the principles of price transparency found in AMA policies such as D-155.987 and CMS Report 4-A-15 on price transparency.

Policy 14 – 2017 – Maintain Rights of County Medical Societies

1. The OSMA will recognize and respect the independent structure, organization and domain of the actively functioning county medical societies in the state of Ohio.
2. The rights of the county medical societies to appoint their representatives to serve in the OSMA House of Delegates shall be preserved.

Policy 15 – 2017 – Maintain the House of Delegates as the Legislative Body of the OSMA

1. The OSMA House of Delegates shall remain in place as the legislative body of the OSMA, retaining all rights, privileges and authority as are now set forth in the OSMA Constitution and Bylaws.
2. The quorum of the HOD will be satisfied with the presence of the majority of the registered delegates. This will require a bylaws change and the OSMA Council is directed to write the appropriate language for voting at the annual meeting in 2018.
3. From 45 days up to the annual meeting of the HOD, underrepresented counties can be assigned active OSMA members who reside or work in that county or district by the district councilor to serve at the HOD. This may require a bylaws change and the OSMA Council is directed to write the appropriate language for voting at the annual meeting in 2018.

Policy 16 – 2017 – Limit the OSMA Council’s Attempts to Dissolve the House of Delegates

1. The OSMA Council shall propose no action to dissolve the OSMA House of Delegates absent specific direction from the House of Delegates.

Policy 17 – 2017 – Importance of OSMA Promoting Physician Well-Being by Addressing the Physician and Medical Student Burnout Issue

1. The OSMA shall work with medical schools, hospitals, residency programs, and physicians to address the issue of physician and medical student burnout.
2. The OSMA encourages physicians and medical students to utilize the AMA Steps Forward Program to learn more about preventing physician burnout.

Policy 19 – 2017 – Opioid Harm Reduction in Undergraduate Medical Education

1. The OSMA shall support inclusion of harm reduction strategies in pain management, including, but not limited to, prescribing and discontinuation of opioid medications in medical school curricula.

Policy 20 – 2017 - Ohio Physicians and the Opioid Problem

1. That it is the Official Policy of the OSMA that all physicians should have the ability to prescribe all medications, including controlled substances, using the highest standards of care and professionalism, providing the best possible care to each patient. All physicians should work diligently to help find solutions to the problems of abuse of prescription medications, use and overdose of illegal substances, and opioid overdose. Physicians acknowledge that substance abuse has many factors and that physicians have contributed to overuse of opioids. However, other causes of misuse of controlled substances should be the significant focus of remedial action.

Policy 21 – 2017 – Removal of Non-Medical Exemptions for Mandated Immunizations and Support of Immunization Registries

1. The OSMA supports the use of immunizations to reduce the incidence of preventable diseases.
2. The OSMA supports the removal of non-medical exemptions for required school immunizations.
3. The OSMA encourages the use of immunization reporting systems for patients of all ages.

Policy 22 – 2017 – Opposition to the Practice of LGBTQ “Conversion Therapy” or “Reparative Therapy”

1. The OSMA affirms that individuals who identify as homosexual, bisexual, transgender, or are otherwise not heteronormative are not inherently suffering from a mental disorder.

2. The OSMA strongly opposes the practice of “Conversion Therapy,” “Reparative Therapy” or other techniques aimed at changing a person’s sexual orientation or gender identity.

Policy 23 – 2017 – Advocating for Increased Awareness and Education of Human Trafficking

1. The OSMA shall advocate against human trafficking.
2. The OSMA will encourage the education of physicians on how to identify and assist victims of human trafficking.

Policy 24 – 2017 – Advocating for Needle Exchange Programs

1. The OSMA shall advocate for the adoption of standardized and holistic needle exchange programs in Ohio, particularly in underserved areas.
2. The OSMA shall advocate for educational programs regarding the safe disposal of used needles and syringes.
3. The OSMA encourages physicians to refer their patients to Needle Exchange Programs.

Policy 25 – 2017 – Longitudinal Approach to Cultural Competency Dialogue on Eliminating Health Care Disparities

1. The OSMA encourages all medical education institutions in Ohio to engage in expert facilitated, evidence-based dialogue in cultural competency and the physician’s role in eliminating cultural health care disparities in medical treatment.

Policy 26 – 2017 – Opposition to Anti-Competitive Insurance Mergers

1. The OSMA opposes any merger in the health insurance industry that results in anticompetitive markets and/or limits patient access to quality healthcare.

Policy 27 – 2017 – Ban Restrictive Covenants for Physicians Employed by Hospitals in Ohio

1. The OSMA shall lobby for state legislation to ban restrictive covenants in contracts between hospitals or hospital systems and their employed physicians in Ohio.

Policy 28 – 2017 – OSMA to Lobby to Amend the Ohio Revised Code to Read that The Ohio State Board of Pharmacy Will Regulate the Compounding by Pharmacists of Dangerous Drugs, but Not Such Compounding by Licensed Physicians

1. The OSMA will lobby to amend the Ohio Revised Code to read that The Ohio State Board of Pharmacy may regulate compounding of dangerous drugs by pharmacists, but not such compounding by licensed physicians.

Policy 01 – 2018 – Constitution and Bylaws Amendments

1. The OSMA Constitution and Bylaws were updated to incorporate the changes adopted by the 2018 OSMA House of Delegates. The OSMA Constitution and Bylaws Updated April 2018 are available on www.osma.org.

Policy 02 – 2018 – Young Physicians

1. Policy 02 – 2018 created a Young Physicians Section. The OSMA Constitution and Bylaws were updated to incorporate the changes adopted by the 2018 OSMA House of Delegates. The OSMA Constitution and Bylaws Updated April 2018 are available on www.osma.org.

Policy 03 – 2018 – Pursuit of a Strategic Partnership with the Ohio Public Health Association

1. The OSMA create a formal partnership, establishing an open line of communication, with the Ohio Public Health Association for medical students and physicians.
2. The OSMA support policies and initiatives that may, based on reasonable evidence, produce population health improvements, as well as incentivize healthcare providers, hospitals, clinics, and other healthcare facilities to engage in health promotion.

Policy 04 – 2018 – Policy Finder and Bylaws

1. The OSMA maintain an up-to-date OSMA policy database, preferable in a searchable format, readily available on its website at all times.
2. That the OSMA maintain a readily accessible copy of our current Constitution and Bylaws available on its website at all time.

Policy 05 – 2018 – Hospital Closures

1. The OSMA develop a protocol which would be followed in the event of a hospital closing within the state to include, but not be limited to:
 - 1) Working with the local county medical society to hold “town hall” meetings for the affected physicians.
 - 2) Act as a clearinghouse for displaced physicians/residents in order to help identify alternative practice/educational options and to help expedite transition to these new opportunities.
 - 3) Coordinate with hospital officials in the area to ensure a seamless transition of care for patients.
 - 4) Help to ensure that access to medical records for patients is appropriately maintained.
 - 5) Work with state and local officials to ensure that access to care is not compromised for patients in a given region.
2. The OSMA work with the Ohio Hospital Insurance Association to develop a protocol in the event of an impending closure of a hospital within the state, which would 1) call for appropriate notifications to the medical staff and community in a timely and professional deliberate manner, and 2) ensure that the method to achieve affordable access to patient medical records is communicated to all concerned parties.
3. The OSMA will work with the Ohio Hospital Association to develop a template letter regarding the medical staff membership status of affected physicians and/or residents at the time of hospital closure, thereby having easily accessible documentation certifying that their departure from the medical staff was not by voluntary activities or due to sanctions.
4. The OSMA will work with the American Medical Association and its organized medical staff section to develop a repository of information regarding the medical staff membership status of affected physicians and/or residents at the time of hospital closure, thereby having easily accessible documentation certifying that their departure from the medical staff was not by voluntary activity or due to sanctions.

Policy 06 – 2018 – Access to Medical Records

1. Patients’ medical records should be accessible to patients and their physicians after hospital closures.
2. Patients’ medical records should be accessible to patients and their new physicians when a physician’s office closes for whatever reason, including retirement, loss of employment or leaving the community in compliance with existing Ohio statutes and State Medical Board of Ohio policy.

Policy 07 – 2018 – United States Medical Licensing Examination Step 2 Clinical Skills Examination

1. The OSMA supports the following AMA policy regarding clinical skills assessment during medical school:

AMA Policy D-295.988

1. *Our AMA will encourage its representatives to the liaison committee on medical education (LCME) to ask the LCME to determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should "develop a system of assessment" to assure that students have acquired and can demonstrate core clinical skills.*
2. *Our AMA will work with the Federation Of State Medical Boards, National Board of Medical Examiners, state medical societies, state medical boards, and other key stakeholders to pursue the transition from and replacement for the current United States Medical Licensing Examination (USMLE) step 2 clinical skills (CS) examination and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) level 2-performance examination (PE) with a requirement to pass a Liaison Committee on Medical Education-Accredited or Commission on Osteopathic College Accreditation-Accredited Medical School-Administered, clinical skills examination.*
3. *Our AMA will work to: (a) ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through immediate steps by the Federation of State Medical Boards And National Board of Medical Examiners; (b) encourage a significant and expeditious increase in the number of available testing sites; (c) allow international students and graduates to take the same examination at any available testing site; (d) engage in a transparent evaluation of basing this examination within our nation's medical schools, rather than administered by an external organization; and (e) include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency.*
4. *Our AMA is committed to assuring that all medical school graduates entering graduate medical education programs have demonstrated competence in clinical skills.*
5. *Our AMA will continue to work with appropriate stakeholders to assure the processes for assessing clinical skills are evidence-based and most efficiently use the time and financial resources of those being assessed.*
6. *Our AMA encourages development of a post-examination feedback system for all USMLE test-takers that would: (a) identify areas of satisfactory or better performance; (b) identify areas of suboptimal performance; and (c) give students who fail the exam insight into the areas of unsatisfactory performance on the examination.*
7. *Our AMA, through the Council on Medical Education, will continue to monitor relevant data and engage with stakeholders as necessary should updates to this policy become necessary.*

Policy 08 – 2018 - Equality for COMLEX and USMLE

1. The OSMA promote acceptance of the United States Medical Licensing Examination (USMLE) and Comprehensive Osteopathic Medical Licensing Examination (COMLEX) as equivalent by all Ohio residency programs.

Policy 09 – 2018 - Mentorship

1. The OSMA will work to establish a physician-trainee mentorship program that provides value for all involved parties.

Policy 10 - 2018 – Terminal Distributor License

1. Physician practices are and must remain under the authority of the State Medical Board of Ohio and never under the Ohio Board of Pharmacy.
2. The OSMA is opposed to the requirement in the Ohio Revised Code requiring physicians to obtain the Category II License for the Terminal Distributor of Dangerous and will actively lobby for its elimination.

Policy 11 – 2018 - On-Line Controlled Drugs

1. The OSMA encourage the American Medical Association to work to change the laws to help the Drug Enforcement Administration and the Food and Drug Administration to better regulate and control the online sales and distribution of controlled substances that lack a valid prescription.

Policy 12 – 2018 - Dietary Supplements

1. The OSMA educate our patients as to the risks and danger of taking non-prescribed dietary supplements.
2. The OSMA supports existing AMA policy regarding dietary supplements and herbal remedies as follows:

Dietary Supplements and Herbal Remedies H-150.954

1. *Our AMA will work with the FDA to educate physicians and the public about FDA's Medwatch program and to strongly encourage physicians and the public to report potential adverse events associated with dietary supplements and herbal remedies to help support FDA's efforts to create a database of adverse event information on these forms of alternative/complementary therapies.*
2. *Our AMA continues to urge congress to modify the dietary supplement health and education act to require that (a) dietary supplements and herbal remedies including the products already in the marketplace undergo FDA approval for evidence of safety and efficacy; (b) meet standards established by the United States Pharmacopeia for identity, strength, quality, purity, packaging, and labeling; (c) meet FDA post-marketing requirements to report adverse events, including drug interactions; and (d) pursue the development and enactment of legislation that declares metabolites and precursors of Anabolic steroids to be drug substances that may not be used in a dietary supplement.*
3. *Our AMA work with the Federal Trade Commission (FTC) to support enforcement efforts based on the FTC act and current FTC policy on expert endorsements.*
4. *Our AMA supports that the product labeling of dietary supplements and herbal remedies: (a) that bear structure/function claims contain the following disclaimer as a minimum requirement: "this Product has not been evaluated by the Food And Drug Administration and is not intended to diagnose, mitigate, treat, cure, or prevent disease." this product may have significant adverse side effects and/or Interactions with medications and other dietary supplements; therefore it is important that you inform your doctor that you are using this product; (b) should not contain prohibited disease claims.*
5. *Our AMA supports the FDA's regulation and enforcement of labeling violations and FTC's regulation and enforcement of advertisement violations of prohibited disease claims made on dietary supplements and herbal remedies.*
6. *Our AMA urges that in order to protect the public, manufacturers be required to investigate and obtain data under conditions of normal use on adverse effects, contraindications, and possible drug interactions, and that such information be included on the label.*
7. *Our AMA will continue its efforts to educate patients and physicians about the possible ramifications associated with the use of dietary supplements and herbal remedies.*

Policy 13 – 2018 - Support of Competitive, Transparent Pricing Models by Pharmacy Benefit Managers

1. The OSMA supports competitive, transparent drug pricing by Pharmacy Benefit Managers.

Policy 14 – 2018 - Protection of the Patient-Physician Relationship in Controversial Legislation

1. The OSMA actively oppose any legislation or rule that would negatively impact the sanctity of the physician/patient relationship.

Policy 15 – 2018 - Arbitrary Paperwork and Signature Deadlines for Hospital and Rehabilitation Unit Admission

1. The OSMA work to decrease the paperwork burden including arbitrary signature requirements that do not change the medical necessity of an admission.

2. The OSMA work with our Ohio Congressional Delegation and our American Medical Association to change admission order signature timeframe regulations at the Centers for Medicare and Medicaid Services to be consistent with timeframe regulations for other verbal and telephone orders.

Policy 16 – 2018 - E-Card

1. The OSMA encourage the establishment of an electronic health insurance verification card system in the State of Ohio.

Policy 17 – 2018 – OSMA to Seek Time Parity for Physician Claims Filing and Insurance Take Back

1. The OSMA again make every effort to limit the allowed time for insurance companies “look back/take back” payments to be commensurate to the time frame allowed for physicians to file claims.

Policy 18 - 2018 – Modifier 25

1. The OSMA supports that an Evaluation & Management code billed with a modifier 25 on the same day as a procedure should be paid in full, and not subject to any reduction.

Policy 19 – 2018 - Prior Authorization for Durable Medical Equipment (DME)

1. Denials of prior authorization for durable medical equipment (DME) must be based on true medical necessity not arbitrary time limits or other paperwork issues.
2. The OSMA continue to work to improve the prior authorization process including working with our Ohio Congressional Delegation and our American Medical Association to improve the process for Medicare Managed Care plans.
3. The OSMA Delegation take this policy to the American Medical Association Annual Meeting.

Policy 20 – 2018 - Compensation for Pre-Authorization Requests

1. The OSMA supports the ability for all Ohio physicians to be compensated for time dedicated to the pre-authorization process.
2. The OSMA requests that payors provide an explanation of their appeals review processes.
3. The OSMA-AMA representatives carry a resolution to the AMA asking the AMA to petition the Centers for Medicare and Medicaid services that CPT code 99080 be reimbursed by Medicare

Policy 21 – 2018 - Fairness in Commercial Health Insurance Network Panels

1. The OSMA adopt a position that commercial health insurance companies should be transparent in all policies toward physicians.

Policy 23 – 2018 - Maintaining Medicaid Coverage for Group VIII Enrollees

1. The OSMA supports the ongoing coverage of those individuals defined as Medicaid group VIII eligible individuals by any program deemed to continue their coverage in a manner comparable to coverage as allowed by the Affordable Care Act, and oppose programs which would not continue commensurate coverage.

Policy 24 – 2018 - Implementation of Integrated Behavioral Healthcare Management Services

1. The OSMA support efforts to implement evidence-based, physician-led integrated behavioral health care management models.

Policy 25 – 2018 - Support of Acupuncture for Chronic Pain Management

1. The OSMA support acupuncture coverage by insurance companies as a strategy for chronic pain management.
By official action, the House reaffirmed existing policy 13-2016.

Emergency Policy No. 01 – 2018 - Firearms and Public Health

1. The OSMA opposes gun violence and supports policy that enforces patient safety.
2. The OSMA lobby for physician immunity from civil and criminal liability, if physicians are required to report potential violent threats by patients.
3. The OSMA encourages firearm safety education.

Emergency Policy 10 – 2018 was reaffirmed at the 2019 OSMA House of Delegates.

Policy 01 - 2019 – Membership Participation Rights

1. That the OSMA Constitution and Bylaws be amended as follows (only affected Sections shown):

ARTICLE III COMPOSITION OF THIS ASSOCIATION

Section 1. Classes of Members. The Voting Members of this Association shall consist of the following classes of members who have paid the appropriate dues amounts, if any, to the association by January 31 of each year: active members:

1. retired members
2. members in training
3. military members
4. student members

Non-voting members of this association shall consist of the following classes of members who have paid the appropriate dues amounts, if any, to the association by January 31 of each year: non-resident members; honorary members; affiliate members; associate members.

ARTICLE V MEETINGS

Section 6. Conduct of Meetings. Meetings of the Association may be held in person or by means of authorized communications equipment as defined in this Article if use of such equipment is approved by the Council except as stated in Section 2 of this Article. Voting members who are not physically present at a meeting of voting members may attend the meeting by the use of authorized communications equipment that enables the voting members an opportunity to participate in the meeting and to vote on matters submitted to the voting members, including an opportunity to read or hear the proceedings of the meeting, participate in the proceedings, and contemporaneously communicate with the persons who are physically present at the meeting. Any voting member who uses authorized communications equipment is deemed to be present in person at the meeting whether the meeting is held at a designated place or solely by means of authorized communications equipment. The Council may adopt procedures and guidelines for the use of authorized communications equipment in connection with a meeting of

voting members to permit the Association to verify that a person is a voting member and to maintain a record of any vote or other action taken at the meeting.

BYLAWS

CHAPTER 1 MEMBERSHIP

Section 1. Rights of Members. All members in good standing of this Association shall have the right to attend all meetings of this Association.

Section 2. Classification of Membership.

(a) Active Members. The active Members of this Association are those physicians in good standing with the OSMA who practice, work or reside in Ohio and who pay the appropriate dues to this association by January 31 of each year. Active Members in good standing shall have the right to vote and hold office.

(b) Retired Members. Retired Members of this Association shall be those members of this Association who have retired from the active practice of medicine and who do not receive regular and significant income for their participation in any professional activity related to the practice of medicine. They must have been Members of this Association and in good standing for ten (10) years prior to retirement. Retired Members shall have the right to vote and hold office.

(c) Members in Training. Members in Training shall comprise all physicians who are pursuing studies and training in a program accredited by the Accreditation Council for Graduate Medical Education (ACGME), the American Medical Association or the American Osteopathic Association and their associated groups and who are approved for membership by the Council. Members in Training shall comprise the Resident and Fellows Section and shall have the right to vote and hold office.

(d) Nonresident Members. Nonresident Members shall include those physicians who reside and practice outside Ohio but who hold a license to practice medicine and surgery in Ohio or any other state and who are approved for Nonresident Membership by the Council.

(e) Honorary Members. The House of Delegates may elect as an Honorary Member any person distinguished for services or attainments in medicine or the allied sciences or who has rendered other services of unusual value to medicine. An Honorary Member shall pay no dues or assessments.

(f) Military Members. Military Members comprise all those Active Members of this Association in good standing who are serving a limited tour of active duty with the Armed Services of the United States.

(g) Life Active Members. Individuals who currently are Life Active Members having made a single payment for lifetime membership dues will continue as Life Active Members, but no new life memberships will be permitted. Life Active Members will have all of the rights and privileges of an Active Member under these Bylaws for life. Wherever the term "Active Member" is used in these Bylaws it shall include Life Active Members.

(h) Affiliate Members. Executives of the Ohio State Medical Association, county medical societies in Ohio, and other medical organizations in Ohio and specialty societies in Ohio with three (3) years or more experience in the sponsoring organization or individuals recommended by a county medical society in Ohio, medical specialty society in Ohio, or physician representative organization in Ohio are eligible for Affiliate Membership in the Ohio State Medical Association. Such Affiliate Membership shall be at the discretion of the Council.

(i) Student Members. Student Members of this Association shall comprise those students in good standing who are pursuing the diploma of Doctor of Medicine or Doctor of Osteopathy in an approved medical or osteopathic college or institution in the State of Ohio and are approved for Student Membership by the Council. Student Members shall comprise the medical group known as the Medical Student Section. Said section shall be governed by and operate under separate Bylaws approved

by the Council. Except as otherwise provided in Article VII of the Constitution, Student Members in good standing of this Association shall have the right to vote and hold office in this Association.

(j) Associate Members. Non-physician administrators and managers of medical practices are eligible for Associate Membership. Associate Members of the Ohio State Medical Association may attend all meetings of the Association, but shall not have the right to make a motion, vote or hold office in this Association.

Section 3. Eligibility. To be eligible for any class of membership other than honorary, affiliate, associate, retired or student in this Association, a person must hold a limited, temporary, or unlimited certificate to practice medicine and surgery, or osteopathic medicine and surgery, issued by the licensing authority of the State of Ohio, which license must be in full force and effect.

Section 4. Disqualification. No person whose license to practice medicine and surgery, or osteopathic medicine and surgery, issued by the licensing authority of the state of Ohio has expired, been suspended or revoked shall be entitled to any of the rights or benefits of this Association.

Section 5. Effect of Expiration, Revocation, or Termination of Certificate. Membership in this Association of a member in active practice whose certificate to practice medicine and surgery has expired, has been revoked, or has been otherwise terminated, shall be cancelled automatically as of the effective date of such expiration, revocation or termination. The provisions of this Section 5 shall not apply to members who have retired from active practice or to members whose certificate has been voluntarily surrendered due to illness, or to members whose license has automatically expired because of problems of communication.

CHAPTER 4 THE HOUSE OF DELEGATES

Section 2. Ratio of Representation. Each Component Society shall be entitled to one (1) delegate in the House of Delegates for each one hundred (100) active members; and retired members in good standing in this Association as of December 31st of the preceding year; provided, however, that each Component Society shall be entitled to at least one (1) delegate and one (1) alternate delegate. If the total number of active Members; and retired Members in good standing in the Component Society is not evenly divisible by one hundred (100), that Component Society shall be entitled to one (1) additional delegate in the House of Delegates. The names of such delegates and alternate delegates shall be submitted to the Association prior to the opening of the House of Delegates.

Members in Training and Students are represented through separately seated sections of the House of Delegates and shall not be included in the member count/ratio of representation of component societies for purposes of determining component society representation in the House of Delegates.

From forty-five (45) days up to the opening of the Annual Meeting of the House of Delegates, in case a Delegate or Alternate Delegate of a Component Society is unable to serve, the district Councilor representing that Component Society may at any time certify to the Chair of the Committee on Credentials the name of an Active OSMA Member who resides or works within the district to serve in the place of such absent Delegate or absent Alternate Delegate. The Committee on Credentials shall rule on the eligibility of such certified individual or individuals to act in the place of such absent Delegate or Alternate Delegate.

Policy 02 - 2019 – OSMA Elections

1. That the OSMA Constitution and Bylaws be amended as follows (showing only affected sections):

ARTICLE IV

HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of this Association and shall consist of: (1) Delegates Selected by the Active and retired Members residing or working within designated OSMA districts; (2) Officers of this Association enumerated in Article V; (3) Delegates and Alternate Delegates to the American Medical Association from Ohio, Past Presidents and Past Councilors of this Association each of whom shall be an ex-officio member without the right to vote unless such Delegate, Alternate Delegate or Past President be a duly elected Delegate or a duly elected officer of this Association; and (4) such representatives of other medical groups as may be determined by the House of Delegates, including the following:

The Medical Student Section shall have seven (7) representatives to the House of Delegates, said Delegates to be selected in accordance with the Bylaws of the Medical Student Section; provided that the Bylaws of the Medical Student Section have been approved by Council. For purposes of representation in the House of Delegates, Student Members shall not be counted at the individual district level, but shall constitute a separate section which shall be treated and seated as if it were an additional district in which the Student Members of each Ohio medical and osteopathic medical school elect their own Delegate.

The Organized Medical Staff Section shall have one (1) representative to the House of Delegates, said Delegate to be selected in accordance with Bylaws of the Organized Medical Staff Section; provided that the Bylaws of the Organized Medical Staff Section have been approved by Council.

The Resident and Fellows Section shall have five (5) representatives to the House of Delegates who must be Members in Training of this Association, said representatives to be selected in accordance with the Resident and Fellows Section Bylaws; provided that the Bylaws of the Resident and Fellows Section have been approved by Council. For purposes of representation in the House of Delegates, Members in Training shall not be counted at the individual district level, but shall constitute a separate section which shall be treated and seated as if it were an additional district in which the Members in Training elect their own delegates.

The Young Physician Section shall have five (5) representatives to the House of Delegates who must be physicians in active practice and under the age of forty or in the first eight years of practice after residency and fellowship training. The Young Physician Section Delegates shall be selected in accordance with the Young Physicians Section bylaws; provided that the bylaws of the Young Physician Section have been approved by Council.

The primary medical specialties and subspecialties listed by the American Board of Medical Specialties are eligible to have a Delegate and Alternate Delegate to be selected in accordance with Chapter 4, Section 3 of the Bylaws of this Association.

The medical subspecialty societies whose members hold such subspecialty certificates approved by the American Board of Medical Specialties with 100 or more members in Ohio and, of whom, at least 50% are OSMA members are eligible to have a Delegate and Alternate Delegate to be selected in accordance with Chapter 4, Section 3 of the Bylaws of this Association.

BYLAWS

CHAPTER 4 THE HOUSE OF DELEGATES

Section 2. Ratio of Representation. Each OSMA district shall be entitled to one (1) Delegate and one alternate delegate in the House of Delegates for each one hundred (100) Active Members-and Retired Members working or residing in the district as of December 31st of the preceding year; provided, however, that each county within a district shall be entitled to at least one (1) Delegate and one (1) Alternate Delegate who works or resides in the county. If the total number of Active Members and Retired Members in good standing in the district is not evenly divisible by one hundred (100), that district shall be entitled to one (1) additional Delegate in the House of Delegates. The names of such Delegates and Alternate Delegates shall be submitted to the Association prior to the opening of the House of Delegates.

Members in Training and Students are represented through separately seated sections of the House of Delegates and shall not be included in the member count/ratio of representation of OSMA districts for purposes of determining representation in the House of Delegates.

From forty-five (45) days up to the opening of the Annual Meeting of the House of Delegates, in case a district Delegate or Alternate Delegate is unable to serve, the district Councilor representing that district may at any time certify to the Chair of the Committee on Credentials the name of an Active OSMA Member who resides or works within the district to serve in the place of such absent Delegate or absent Alternate Delegate. The Committee on Credentials shall rule on the eligibility of such certified individual or individuals to act in the place of such absent Delegate or Alternate Delegate.

Section 3. Representation of Medical Specialties. All primary medical specialties listed by the American Board of Medical Specialties are eligible for representation in the House of Delegates. All medical subspecialty societies whose members hold such subspecialty certificates approved by the American Board of Medical Specialties with 100 or more members in Ohio and, of whom, at least 50% are OSMA members, are eligible for representation in the House of Delegates. An OSMA member may be represented by only one subspecialty organization in the OSMA House of Delegates.

A medical specialty or subspecialty society seeking representation shall apply to the Council. The Council shall consider applications and then recommend to the House of Delegates whether the specialty society qualifies for representation.

Each medical specialty and subspecialty society approved by the OSMA House of Delegates shall have one (1) Delegate and one (1) Alternate Delegate who must be Voting Members of this Association. Each specialty society will certify to this Association at least sixty (60) days prior to the Annual Meeting both the names of its Delegate and Alternate, and its membership certification as required above. In case a Delegate or Alternate Delegate is unable to serve, the President of the recognized medical specialty society may at any time certify to the Chair of the Committee on Credentials the name of a Voting Member of this Association to serve in place of the absent Delegate or absent Alternate Delegate. The Committee on Credentials shall rule on the eligibility of such certified individual or individuals to act in the place of such absent Delegate or Alternate Delegate. A Medical Specialty or subspecialty Society Delegate shall have all rights, privileges and duties as other Delegates. The Delegate will be seated in the House of Delegates with the Councilor District in which that Delegate's Component Society is represented.

Section 11. Councilor Districts. The House of Delegates shall establish Councilor Districts. The districts shall comprise one (1) or more contiguous counties. Each councilor district shall determine the process to be used in the district for selecting delegates and alternate delegates to the OSMA House of Delegates. The district councilor shall submit the process in writing to the OSMA council for approval. All voting members in the councilor district will be eligible to vote for the district councilor. Each nominee for district councilor must be a resident of or work or conduct a majority of their practice in the councilor district for which that nominee for councilor is nominated. The OSMA shall allocate funding for one physical meeting of a council district in preparation for the OSMA annual meeting, if requested by the district councilor, and shall assist in conducting any necessary district-wide elections.

CHAPTER 5 NOMINATION AND ELECTION OF OFFICERS

Section 1. Committee on Nominations. 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.

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 from the Organized Medical Staff Section, the Resident and Fellows Section, the Medical Student Section and the Young Physician Section, except that in 2019 the Committee on Nominations shall name the

initial Young Physician nominee for a seat on the OSMA Council, and the Committee shall not alter or add to these section nominations.

The six at-large council seats shall be elected at large in annual statewide direct elections. 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.

OSMA officers and delegates and alternate delegates to the American Medical Association shall be elected by the House of Delegates.

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 membership of the selection criteria used. The Committee on Nominations shall also determine how best to solicit candidates.

Section 4. Nomination and Elections at the House of Delegates. Nominations for officers, section councilors and AMA delegates and alternate delegates shall be made by the Committee on Nominations at the first session of the House of Delegates. Only those candidates may be nominated whose names have been filed with the Committee on Nominations through the office of the Chief Executive Officer. 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.

Section 7. Election of Officers and of Delegates and Alternate Delegates to the American Medical Association. If there is more than one (1) nominee for an office, the election of officers of this Association and of delegates and alternate delegates to the American Medical Association shall be by ballot during the House of Delegates. The alternate delegates from the Resident and Fellows Section and the Medical Student Section shall be selected in accordance with the Bylaws of their respective sections.

In the event there is only one (1) position to be filled, the nominee receiving the majority of all votes cast shall be declared elected. In case no nominee receives a majority on the first (1st) ballot, the two (2) nominees receiving the lowest number of votes shall be dropped and a new ballot taken; this procedure shall be continued until there are two (2) nominees remaining. The nominee receiving a majority of all votes cast shall be declared elected.

In the event there is more than one (1) position to be filled from among any number of nominees, a nominee, in order to be declared elected, must receive the votes of a majority of those voting, provided, however, that if upon any ballot the number of nominees receiving a majority vote is greater than the number of positions to be filled on such ballot, those nominees (not to exceed the number of positions to be filled on such ballot) receiving the greatest number of votes shall be declared elected. If upon any ballot some, but not all of such positions are filled, a new ballot shall be taken from among all of the remaining nominees; except that the two (2) nominees receiving the lowest number of votes on the previous ballot shall be dropped on each new ballot until there are two (2) more nominees than positions available, after which the nominee receiving the lowest number of votes shall be dropped. On every ballot a nominee, in order to be declared elected, must receive the votes of a majority of those voting, provided, however, that if upon such new ballot the number of nominees receiving a majority vote is greater than the number of positions to be filled on such ballot, those nominees (not to exceed the number of positions to be filled on such ballot) receiving the greatest number of votes cast shall be declared elected. If upon any ballot no nominee receives the votes of a majority of those voting, the two (2) nominees receiving the lower number of votes shall be dropped and a new ballot will be taken; this procedure shall be continued until there are two (2) more nominees than positions available, after which the nominee receiving the lowest number of votes shall be dropped; and this procedure shall be continued until all positions have been filled. No ballot shall be counted if it contains fewer or more votes than the number of positions to be filled or if the ballot purports to cast more than one (1) vote for any nominee. (For example: if upon any ballot the number of positions to be filled is four (4), then each Delegate voting must vote for four (4) of the nominees for such positions.)

**CHAPTER 6
DUTIES AND TERMS OF OFFICERS AND OF THE CHIEF EXECUTIVE OFFICER**

Section 6. Terms of Officers. The President shall serve one (1) year and shall be succeeded by the President-Elect. The term of office of the Secretary-Treasurer shall be for three (3) years. The term of office of Councilors shall be for two (2) years. Councilors of the odd-numbered districts shall be elected in even-numbered years; and the Councilors of the even-numbered districts shall be elected in odd numbered years. All these Officers shall serve until their successors are elected and qualified.

For the purposes of this section, the period from one Annual Meeting until the next shall be regarded as one (1) year.

**CHAPTER 7
THE COUNCIL**

Section 7. Elections and Vacancies. The council shall develop rules and procedures for the conduct of statewide and district wide elections. In the event of a conflict between district wide election procedures developed by the council and the process developed by a councilor district in chapter 4, section 11 of these bylaws, the process developed by the district shall be used to conduct elections. Except as otherwise provided by Chapter 6 hereof, the Council shall fill by appointment any vacancy in office occurring in the interval between the Annual Meetings of the House of Delegates or a statewide or district wide election. Any such appointee shall serve until the next district or statewide election or Annual Meeting of the House of Delegates at which time the office shall be filled in the manner provided for in the Constitution and in these Bylaws.

**CHAPTER 11
MEMBERSHIP IN COMPONENT SOCIETIES**

Section 1. Qualifications for Membership in a Component Society. Each Component Society shall be the sole judge of the qualifications necessary for any and all classes of membership in such society.

Policy 03 - 2019 – Increase Specialty Participation in the HOD

1. That the OSMA Constitution and Bylaws be amended as follows (showing only affected sections):

**ARTICLE IV
HOUSE OF DELEGATES**

The House of Delegates shall be the legislative body of this Association and shall consist of: (1) Delegates elected by the Active Members of the OSMA; (2) Officers of this Association enumerated in Article V; (3) Delegates and Alternate Delegates to the American Medical Association from Ohio, Past Presidents and Past Councilors of this Association each of whom shall be an ex-officio member without the right to vote unless such Delegate, Alternate Delegate or Past President be a duly elected Delegate or a duly elected officer of this Association; and (4) such representatives of other medical groups as may be determined by the House of Delegates, including the following:

The Medical Student Section shall have seven (7) representatives to the House of Delegates, said Delegates to be selected in accordance with the Bylaws of the Medical Student Section; provided that the Bylaws of the Medical Student Section have been approved by Council. For purposes of representation in the House of Delegates, Student Members shall not be counted at the individual district level, but shall constitute a separate section which shall be treated and seated as if it were an additional district in which the Student Members of each Ohio medical and osteopathic medical school elect their own Delegate.

The Organized Medical Staff Section shall have one (1) representative to the House of Delegates, said Delegate to be selected in accordance with Bylaws of the Organized Medical Staff Section; provided that the Bylaws of the Organized Medical Staff Section have been approved by Council.

The Resident and Fellows Section shall have five (5) representatives to the House of Delegates who must be Members in Training of this Association, said representatives to be selected in accordance with the Resident and Fellows Section Bylaws; provided that the Bylaws of the Resident and Fellows Section have been approved by Council. For purposes of representation in the House of Delegates, Members in Training shall not be counted at the individual district level, but shall constitute a separate section which shall be treated and seated as if it were an additional district in which the Members in Training elect their own delegates.

The Young Physician Section shall have five (5) representatives to the House of Delegates who must be physicians in active practice and under the age of forty or in the first eight years of practice after residency and fellowship training. The Young Physician Section Delegates shall be selected in accordance with the Young Physicians Section bylaws; provided that the bylaws of the Young Physician Section have been approved by Council.

The primary medical specialties and subspecialties listed by the American Board of Medical Specialties are eligible to have a one delegate and one alternate delegate for every 100 specialty or subspecialty members who are also OSMA voting members to be selected in accordance with Chapter 4, Section 3 of the Bylaws of this Association.

The medical subspecialty societies whose members hold such subspecialty certificates approved by the American Board of Medical Specialties with 100 or more members in Ohio and, of whom, at least 50% are OSMA members are eligible to have a delegate and alternate delegate to be selected in accordance with Chapter 4, Section 3 of the Bylaws of this Association.

BYLAWS

CHAPTER 4 THE HOUSE OF DELEGATES

Section 2. Ratio of Representation. Each Component Society shall be entitled to one (1) Delegate in the House of Delegates for each one hundred (100) Direct Members residing in the Component County, Active Members, and Retired Members in good standing in this Association as of December 31st of the preceding year; provided, however, that each Component Society shall be entitled to at least one (1) Delegate and one (1) Alternate Delegate. If the total number of Direct Members, Active Members, and Retired Members in good standing in the Component Society is not evenly divisible by one hundred (100), that Component Society shall be entitled to one (1) additional Delegate in the House of Delegates. The names of such Delegates and Alternate Delegates shall be submitted to the Association prior to the opening of the House of Delegates.

Members in Training and Students are represented through separately seated sections of the House of Delegates and shall not be included in the member count/ratio of representation of component societies for purposes of determining component society representation in the House of Delegates.

From forty-five (45) days up to the opening of the Annual Meeting of the House of Delegates, in case a Delegate or Alternate Delegate of a Component Society is unable to serve, the district Councilor representing that Component Society may at any time certify to the Chair of the Committee on Credentials the name of an Active OSMA Member who resides or works within the district to serve in the place of such absent Delegate or absent Alternate Delegate. The Committee on Credentials shall rule on the eligibility of such certified individual or individuals to act in the place of such absent Delegate or Alternate Delegate.

Section 3. Representation of Medical Specialties. All primary medical specialties listed by the American Board of Medical Specialties are eligible for representation in the House of Delegates. All medical subspecialty societies whose members hold such subspecialty certificates approved by the American Board of Medical Specialties with 100 or more members in Ohio and, of whom, at least 50% are OSMA members, are eligible for representation in the House of Delegates. An OSMA member may be represented by only one subspecialty organization in the OSMA House of Delegates.

A medical specialty or subspecialty society seeking representation shall apply to the Council. The Council shall consider applications and then recommend to the House of Delegates whether the specialty society qualifies for representation.

Each medical specialty and subspecialty society approved by the OSMA House of Delegates shall have one (1) Delegate and one (1) Alternate Delegate for every 100 specialty or subspecialty members who are also Voting Members of this Association. Each specialty society will certify to this Association at least sixty (60) days prior to the Annual Meeting both the names of the delegates and alternates selected who must also be Voting Members of the OSMA. The OSMA will verify OSMA membership of the names submitted. In case a Delegate or Alternate Delegate is unable to serve, the President of the recognized medical specialty society may at any time certify to the Chair of the Committee on Credentials the name of a Voting Member of this Association to serve in place of the absent Delegate or absent Alternate Delegate. The Committee on Credentials shall rule on the eligibility of such certified individual or individuals to act in the place of such absent Delegate or Alternate Delegate. A Medical Specialty or subspecialty Society Delegate shall have all rights, privileges and duties as other Delegates. The Delegate will be seated in the House of Delegates with the Councilor District in which that Delegate's Component Society is represented.

Policy 04 - 2019 – Addressing the Pay Gap in Medicine

1. The OSMA supports policies that promote data collection in physician compensation that is de-identified for personal and academic research use.
2. The OSMA supports pay based on objective, gender-neutral criteria.
3. The OSMA supports pay equality to ensure equal pay for equal work.

Policy 05 – 2019 - Advancing Gender Equity in Medicine

1. That OSMA adopt the following, which is adapted from American Medical Association policy/directives:
 - 1) That the OSMA supports gender and pay equity in medicine consistent with the American Medical Association Principles for Advancing Gender Equity in Medicine (see below AMA Policy H-65.961 as adopted at the 2019 AMA Annual Meeting);
 - 2) That the OSMA:
 - (a) Promote institutional, departmental, and practice policies, consistent with federal and Ohio law, that offer transparent criteria for initial and subsequent physician compensation;
 - (b) Continue to advocate for pay structures based on objective, gender-neutral criteria;
 - (c) Encourages training to identify and mitigate implicit bias in compensation decision making for those in positions to determine physician salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement;
 - 3) That the OSMA recommends as immediate actions to reduce gender bias to:
 - (a) Inform physicians about their rights under the Lilly Ledbetter Fair Pay Act, which restores protection against pay discrimination;
 - (b) Promote educational programs to help empower physicians of all genders to negotiate equitable compensation; and
 - (c) Work with relevant stakeholders to advance women in medicine;
 - 4) That the OSMA collaborate with the American Medical Association initiatives to advance gender and pay equity;
 - 5) That the OSMA commit to the principles of pay equity across the organization and take steps aligned with this commitment.

Principles for Advancing Gender Equity in Medicine H-65.961:

Our AMA:

1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., **gender**);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of **gender**;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;
5. acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;
8. affirms that transparency in pay scale and promotion criteria is necessary to promote **gender equity**, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by **gender** and evaluate protocols for advancement to determine whether the criteria are discriminatory; and
9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of **gender** in these skill areas.

Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing **Gender Equity** in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur.

Policy Timeline

BOT Rep. 27, A-19

Policy 06 - 2019 – Increase Awareness of Disparities in Medical Access and Treatment in Ohio

1. That the OSMA work with appropriate stakeholders to increase awareness of Ohio physicians, residents, and medical students of disparities in medical access and treatment in Ohio based on disability, race, ethnicity, geography, and other social and demographic factors through the utilization of existing resources.

Policy 07 - 2019 – Female Genital Mutilation Ban

1. That the Ohio State Medical Association condemns the practice of female genital mutilation as defined by the World Health Organization and considers female genital mutilation a form of child abuse
2. That the Ohio State Medical Association encourages physicians to engage in culturally competent counseling to individuals at risk of female genital mutilation.

Policy 08 - 2019 – HPV Immunization

1. That the Ohio State Medical Association supports increased access to the HPV vaccine.
2. That the OSMA supports adding the HPV vaccine to the current schedule of required vaccines for attendance at public and private schools, subject to existing exemption policies.

Policy 09 - 2019 – Impact of Climate Change on Human Health

1. That the Ohio State Medical Association supports efforts at the state level for expansion of renewable sources of energy.

Policy 13 - 2019 – Hospital Closures and Physician Credentialing Repository

1. That the OSMA take whatever legislative and/or administrative steps necessary to initiate action by the Ohio Department of Health to create and maintain a repository of credentialing files of those physicians affected by hospital closures, so that such records will be easily accessible for future needs.

Policy 14 - 2019 – Compensation for Prior Authorization Services

1. That the OSMA oppose pre-authorization as a requirement for patient care.
2. That OSMA seek legislation that provides for appropriate compensation to physician offices for expenses incurred in obtaining prior authorizations for patient care.

Policy 16 - 2019 – OSMA Support of Direct Primary Care

1. That the Ohio State Medical Association (OSMA) provide a written description of the Direct Primary Care model to physicians and medical students for the purpose of educating on alternative practice models.

Policy 17 - 2019 – Part A Medicare Payments to Physicians

1. That the OSMA work for enactment of legislation to direct cash payments from Part A Medicare to physicians in direct proportion to demonstrated savings that are made in Part A Medicare through the efforts of physicians.
2. That this policy on Part A Medicare Payments to Physicians, be forwarded on to the AMA for consideration at the Annual AMA HOD Meeting in June 2019.

Policy 18 - 2019 – Practice Overhead Expense and the Site-of-Service Differential

1. That the OSMA appeal to the Ohio congressional delegation for legislation to direct CMS to eliminate any site-of-service differential payments to hospitals for the same service that can safely be performed in a doctor's office.
2. That the OSMA appeal to the Ohio congressional delegation for legislation to direct CMS in regards to any savings to Part B Medicare, through elimination of the site-of-service differential payments to hospitals, (for the same service that can safely be performed in a doctor's office), be distributed to all physicians who participate in Part B Medicare, by means of improved payments for office-based Evaluation and Management Codes, so as to immediately redress underpayment to physicians in regards to overhead expense.
3. That the OSMA appeal to the Ohio congressional delegation for legislation to direct CMS to make Medicare payments for the same service routinely and safely provided in multiple outpatient settings (e.g., physician offices, HOPDs and ASCs) that are based on sufficient and accurate data regarding the actual costs of providing the service in each setting.
4. That this policy on practice overhead expense and site-of-service differential be forwarded to our AMA for consideration at the Annual HOD Meeting in June 2019.

Policy 19 - 2019 – Investigate Medicare Part D - Insurance Company Upcharge

1. That the OSMA Delegation to the AMA ask the AMA to investigate Medicare Part D rules which allow insurance providers to keep up to 5% more than their actual cost of providing pharmacy prescription services while at the same time they are eligible to get paid by CMS reinsurance rules for certain losses.

Policy 20 - 2019 – Establishing Fair Medicare Payor Rates

1. That the OSMA Delegation to the AMA ask the AMA to pursue CMS intervention and direction to prevent commercial Medicare payors from compensating physicians at rates below Medicare's established rates.

Policy 21 - 2019 – 2019 Congressional Health Care Proposals

1. That the OSMA supports provisions in Federal and State legislation that:
 - 1) Do not limit the choices available for Americans for health care coverage.
 - 2) Support improving existing health plans.
 - 3) Make any new plan voluntary.
 - 4) Do not eliminate the private insurance market.
2. That the OSMA reaffirm our basic principles for health care (Policy 63 - 1994 and Policy 01 - 2017).
3. That the OSMA AMA Delegation take this policy to the AMA Annual meeting in Chicago for further discussion and action.

Policy 22 - 2019 – Opposition to Medicaid Eligibility Barriers

1. That the Ohio State Medical Association oppose drug testing as a requirement to determine eligibility for Medicaid and applicants.
2. That the Ohio State Medical Association oppose employment criteria for Medicaid enrollees and applicants.

Policy 23 - 2019 – 2019 OSMA Policy Sunset Report

1. That the recommendations of the OSMA Council published prior to the House of Delegates as the 2019 OSMA Policy Sunset Report be adopted by the OSMA House of Delegates.