

2020 OSMA Resolutions

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Introduced by: OSMA District Four

Subject: Multidisciplinary Approach to Safer Care of Obese Patients in Healthcare Settings

Referred to: Resolutions Committee No. 2

WHEREAS, 2016-2017 statistics show Ohio's current obesity rate of 33.8%, ranks nationally as the 11th highest in adult obesity rates and 18.6% in youth's ages 10-17 ranks 6th according to Robert Wood Johnson Foundation 2004-2019 "The State of Obesity; Better Policies for a Healthier America."; and

WHEREAS, According to recent data, adult obesity rates exceed 35% in seven states, 30% in 29 states and 25% in 48 states; and

WHEREAS, Updated September 2019: According to the most recent Behavioral Risk Factor Surveillance System (BRFSS) data, adult obesity rates now exceed 35% in nine states, 30% in 31 states and 25% in 48 states. Mississippi and West Virginia have the highest adult obesity rate at 39.5% and Colorado has the lowest at 23%. Between 2017 and 2018, the adult obesity rate increased in Florida, Kansas, Minnesota, Missouri, New Mexico, New York, and Utah, decreased in Alaska, and remained stable in the rest of states and D.C.; and

WHEREAS, According to the Centers for Disease Control and Prevention. Obesity is also often associated with 236 comorbidities, such as diabetes, hypertension, heart disease, arthritis, depression and 13 different cancers; and

WHEREAS, There are multiple policies in the state of Ohio addressing food insecurity and healthy eating habits such as: "Supplemental Nutrition Assistance Program, Women Infants and Children's Program, Child and Adult Food Care Program, Food Marketing to Children, Healthy Food Financing Initiative" etc.; and

WHEREAS, Ohio has policy addressing healthier activities such as; "Physical Education and Physical Activity in School, Healthy Eating and Physical Activity Standards in Early Care and Education: and

WHEREAS, There is no existing policy of the OSMA addressing patient safety in caring for the obese patient across healthcare settings and the only existing AMA policy only addresses “encouraging policies to help assist with the management of obese patients during positioning and transportation”; **therefore be it**

RESOLVED, That the OSMA develop new policy specifically addressing a multidisciplinary approach to safer care of obese patients across the continuum of care in healthcare settings; and, **be it further**

RESOLVED, That the OSMA work with interested parties including specialty organizations, hospitals, healthcare systems and state health organizations to develop best practice standards in a multidisciplinary approach to safer care of obese patients across the continuum of care in healthcare settings; and, **be it further**

RESOLVED, That the OSMA delegation to the AMA present this resolution to the Organized Medical Staff Section of the AMA to help develop national best practice standards addressing safer care for the obese patient across the continuum of care in healthcare settings.

Fiscal Note: \$ None Provided (Sponsor)
\$ 50,000 (Staff)

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 15 – 2020

Introduced by: OSMA Medical Student Section

Subject: Supporting Gender-Affirming Care for Transgender and Gender Minority Patients

Referred to: Resolutions Committee No. 2

WHEREAS, Gender affirmation refers to the process of being recognized in one's gender identity through social, psychological, legal practices as well as medical activities including pubertal blockers, hormones, surgery, or other body modification¹; and

WHEREAS, Gender-affirmative health care refers to care that is sensitive, responsive, and affirming to transgender patients' gender identities and/or expressions¹; and

WHEREAS, When surveyed in 2015, 32% of transgender patients in Ohio reported a negative healthcare provider interaction due to their gender, 26% avoided needed medical care due to fear of mistreatment by healthcare providers, and 15% reported that a professional tried to stop them from being transgender²; and

WHEREAS, Transgender individuals who delay healthcare because of fear of discrimination are shown to have worse general health and mental health outcomes³; and

WHEREAS, transgender youth are at increased risk of suicide with over 50% of female-to-male transgender youth reporting an attempted suicide (compared to 14.1% among all adolescents)⁴. This rate translates to nearly 500 attempted suicides by Ohioan female-to-male transgender youth alone⁵; and

WHEREAS, Transgender children whose identities are supported show rates of mental illness comparable to cisgender youth, while transgender youth who are not allowed to socially transition show increased rates of mental illness⁶; and

WHEREAS, Transgender youth given gender-affirming treatment showed improved mental wellness and decreased levels of suicidality⁷; and

WHEREAS, Transgender youth and adults face significant barriers to receiving gender-affirming treatments including a scarcity of physicians trained in gender-affirming care, cultural competence of providers and staff, and insurance coverage of treatments^{8,9}; and

WHEREAS, The American Academy of Child and Adolescent Psychiatry supports evidence-based, individualized, gender-affirming care for transgender youth, and opposes any efforts to blocking access to this care¹⁰; and

WHEREAS, Both the American Academy of Pediatricians and the American Academy of Family Physicians have policies in place supporting gender-affirming care^{11,12}; and

WHEREAS, The OSMA has prior policies that support LGBT protections (*OSMA Policy 22-2016; 22-2017*), educational training on cultural competency (*25-2017*), and gender-inclusive intake forms (*23-2016*). While AMA has policies that support gender-inclusive intake forms (*AMA Policy H-315.967; D-315.974*), advocate for education on the spectrum of gender (*D-295.312, H-65.962*), support research on minimizing disparities for transgender and gender minority populations (*H-160.991, H-295.878*), and opposes mandated reporting of gender questioning individuals (*H-65.959*); and

WHEREAS, The 2020-2023 OSMA strategic plan includes a focus on advocacy¹³; **therefore be it**

RESOLVED, That the OSMA reaffirm existing Policy 23-2016 - Expanding Gender Identity Options on Physician Intake Forms (see below relevant policy); and, **be it further**

RESOLVED, That the OSMA supports individualized, gender-affirming, evidence-based treatment and clinical practices in caring for transgender and gender minority patients; and, **be it further**

RESOLVED, That the OSMA supports educational training to further educate healthcare providers on how to provide competent, respectful, evidence-based care to transgender and gender minority patients.

Fiscal Note: \$ 5,000 (Sponsor)
 \$ 5,000 (Staff)

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Relevant OSMA Policy:

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 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.

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

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

1 OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

2
3 Resolution No. 16 – 2020

4
5 Introduced by: OSMA Medical Student Section

6
7 Subject: Strengthen Awareness of the Importance of Good-Faith Prescription
8 Donations to the Ohio Drug Donation Repository and the Free Clinics It
9 Serves

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11 Referred to: Resolutions Committee No. 2
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15 WHEREAS, The rising cost of prescription medications in the United States threatens
16 the financial security of “safety-net/free” clinics^{1,2}; and

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18 WHEREAS, Nationwide demand for the services of free clinics has increased, with more
19 than 1.8 million patients seeking care at 1200+ free clinics nationwide³; and

20
21 WHEREAS, There are 50+ free clinics providing services to over 52,000 patients in
22 Ohio, many also providing prescription assistance to the patients that they serve⁴; and

23
24 WHEREAS, The FDA has recognized the importance of prescription drug donations to
25 free clinics, and stated that the practice is permissible under the Prescription Drug Marketing
26 Act⁵; and

27
28 WHEREAS, Ohio is recognized as an innovator in the area of prescription drug donation
29 for its creation of the Ohio Drug Donation Repository Program, one of the first state-level
30 programs of its kind in the nation, and the first to allow nursing homes, long-term care
31 pharmacies, and wholesalers to become donators⁶; and

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33 WHEREAS, The Ohio State Legislature has passed laws giving immunity from civil
34 liability and criminal prosecution to any entity donating prescription medications to the Ohio
35 Drug Repository Program in good faith⁷; and

36
37 WHEREAS, Despite these civil and criminal protections for donation of prescription
38 medication, participation in the Ohio Drug Repository Program has decreased in previous years
39 due to concerns that these protections are not strong enough⁸; and

40
41 WHEREAS, Prescription donation programs in other states with strong legal protections,
42 such as Iowa, Wyoming, and Oklahoma, have enjoyed greater amounts of donations to their
43 drug donation programs, with each state distributing more than \$10,000,000 in donated
44 medications since the creation of their prescription donation programs in the mid-2000s⁹; and

45
46 WHEREAS, Medications donated have strict safety guidelines set by state laws and the
47 State Board of Pharmacy, reducing the risk of donation⁹; and

48
49 WHEREAS, The greater the out-of-pocket expense of a medication to a patient, the
50 more likely the patient is to be non-adherent¹⁰; and
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WHEREAS, Studies that provided full drug coverage increased adherence in the treatment of chronic illnesses and reduced rates of adverse clinical outcomes¹⁰; and

WHEREAS, Donation of prescription medications is recognized as an important way to expand access to medicine and address the social determinants of health¹¹; and

WHEREAS, In Policy 31 - 1983, the OSMA supports every patient having access to any drug approved by the FDA that his or her physician thinks is helpful¹²; and

WHEREAS, In Policy 62 - 1988, the OSMA supports its members that work with organizations serving the poor¹²; and

WHEREAS, In Policy 06 - 2019, the OSMA supports efforts to increase awareness of disparities to medical access and treatment in the state of Ohio¹²; and

WHEREAS, In the 2020-2023 Strategic Plan, the OSMA pledges to focus its efforts on Advocacy and working towards a Healthier Ohio¹³; **therefore be it**

RESOLVED, That the OSMA support efforts to increase public and private sector awareness of the importance of good-faith prescription donation to the Ohio Drug Donation Repository Program, and the free clinics it serves.

Fiscal Note: \$ 5,000 (Sponsor)
 \$ 5,000 (Staff)

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111
112

113 **Relevant OSMA Policy**

114 **Policy 31 -- 1983 -- Drug Availability**

115 1. Every patient should have available any drug approved by the FDA that his or her physician
116 thinks is needed and helpful.

117 2. The FDA-approved drugs should be reimbursed by third party payers.
118

119 **Policy 62 -- 1988 -- Donation of Professional Time to Poor**

120 1. The OSMA commends its members for continuing to donate professional time to serving the
121 poor.
122

123 **Policy 06 -- 2019 -- Increase Awareness of Disparities in Medical Access and Treatment in** 124 **Ohio**

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

1 OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

2
3 Resolution No. 17 – 2020

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5 Introduced by: OSMA Medical Student Section

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7 Subject: Refining OSMA Position on Healthcare Financing Reform

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9 Referred to: Resolutions Committee No. 2

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13 WHEREAS, The OSMA's mission is "dedicated to empowering physicians, residents
14 and medical students to advocate on behalf of their patients and profession"; and

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16 WHEREAS, Per Policy 63 – 1994 (Health Systems Reform), the OSMA supports "only
17 those proposed changes in our health-care system that are in the best interest of patients and
18 which assure that all Americans continue to receive high quality medical care", and the OSMA
19 supports that "(1) All Americans shall have access to health insurance; (2) The right of patients
20 to choose their physician freely; (3) The right of patients and their physicians to make medical
21 decisions; and

22
23 WHEREAS, The United States (U.S.) has not achieved universal health coverage and
24 uses a multitude of privately-run for-profit health insurers to finance a significant portion of its
25 healthcare, while countries that have achieved universal health coverage use single-payer
26 systems or a mix of public financing with a highly-regulated set of health insurers^{1,2}; and

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28 WHEREAS, The current U.S. health insurance system results in significant financial
29 barriers for patients to access healthcare, as evidenced by the large number of people who lack
30 health insurance (28.6 million Americans, including 744,000 Ohioans had no insurance for all of
31 2018)³ and who are under-insured (23% of Americans were underinsured and 10% had gaps in
32 coverage in 2017-2018)⁴; and

33
34 WHEREAS, Financial barriers to accessing healthcare, such as lack of insurance and
35 under-insurance, are associated with increased morbidity, mortality, delayed care, and
36 bankruptcy⁵⁻⁹; and

37
38 WHEREAS, The current healthcare system is incredibly expensive, as evidenced by the
39 U.S. national health expenditure of \$3.7 trillion (nearly 18% of GDP) in 2017¹⁰ and
40 approximately twice as much per capita as peer nations that provide universal coverage^{1,11}; and

41
42 WHEREAS, The excess healthcare spending in the United States is chiefly due to
43 increased administrative costs and higher prices¹²⁻¹⁶ and countries that have achieved universal
44 health coverage have reduced expenditure by using proven-effective methods, such as
45 simplified billing, global budgets, and negotiated drug prices^{15,17}; and

46
47 WHEREAS, Nearly all economic analyses of universal, government-financed plans in
48 the U.S., performed by academics and organizations from across the political spectrum, predict
49 that these plans would reduce health expenditure while providing universal health coverage¹⁸;
50 and

51

WHEREAS, The complicated billing structure in the U.S. is associated with physicians spending significantly more time and money on administrative tasks (e.g. communicating with insurance companies, hiring staff to handle billing, billing-driven documentation, pre-authorization forms) and these administrative tasks contribute to burnout^{19–23}; and

WHEREAS, The bureaucracy of the current multi-payer system reduces patient freedom by limiting choice of physician²⁴⁻²⁷ and interfering with doctor-patient relationship^{28,29}; and

WHEREAS, A previous transition from a free-market system maintained average physician compensation³⁰; and

WHEREAS, The public is more satisfied with their healthcare system in countries that have achieved universal health coverage than in the U.S.²; and

WHEREAS, Over 70% of Americans support the federal government doing more to help provide health insurance³¹; **therefore be it**

RESOLVED, That the Ohio State Medical Association consider evidence-based proposals to universal health insurance that preserve the freedom of choice, freedom of practice, and universal access for patients; and, **be it further**

RESOLVED, The Ohio State Medical Association rescind 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; and, **be it further**

RESOLVED, That the Ohio State Medical Association amend Policy 05 – 2011 (Universal Health Insurance Coverage) as follows:

1. The OSMA reaffirms support for supports 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; and, **be it further**

RESOLVED, That the Ohio State Medical Association rescind Policy 13 – 1995 (Privatizing Medicare):

1. The OSMA supports privatizing Medicare including the use of the medical savings accounts.; and, **be it further**

RESOLVED, That the Ohio State Medical Association rescind Policy 14 – 1995 (Privatize Medicaid);

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

Fiscal Note: \$ 500 (Sponsor)
\$ 500 (Staff)

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1 OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

2
3 Resolution No. 18 – 2020

4
5 **Introduced by:** The Academy of Medicine of Lima and Allen County

6
7 **Subject:** Time Frames for Insurance Charge Submission

8
9 **Referred to:** Resolutions Committee No. 2

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12
13 **WHEREAS**, Some insurance companies have recently sent notice that they are
14 changing the time to submit charges after a patient encounter from 180 days to 90 days (50%
15 cut in time allowed); and

16
17 **WHEREAS**, The notice of the change was only about 30 days which is too short to allow
18 for process changes that are needed to accomplish this much shorter time frame; and

19
20 **WHEREAS**, The billing office does not always get the correct information about which
21 insurance the patient has in a timely manner and may even bill and get a rejection from another
22 insurance company first before the office can bill the correct company; and

23
24 **WHEREAS**, Insurance companies have done take back of previous payments as long
25 as 4 years after the original payment which is unfair; **therefore be it**

26
27 **RESOLVED**, That the OSMA work to prevent insurance companies from changing the
28 time allowed for physicians to submit charges for services (such as from 180 days to 90 days) in
29 the middle of a contract period; and, **be it further**

30
31 **RESOLVED**, That the OSMA work to require at least 180-day notice if the time to submit
32 charges is decreased by an insurance company; and, **be it further**

33
34 **RESOLVED**, That the OSMA work to limit the time that an insurance company has to
35 take back paid fees to the same amount of time that physicians have to submit charges (i.e. no
36 take back after 90 days, if charges must be submitted in 90 days).

37
38 **Fiscal Note:** \$ 1,000 (Sponsor)
39 \$ 5,000 (Staff)

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 19 – 2020

Introduced by: OSMA District Two

Subject: Out-of-Network Billing

Referred to: Resolutions Committee No. 2

WHEREAS, Many patients receive care from physicians who are not in their insurance company's restrictive network for multiple reasons; and

WHEREAS, This leads to out-of-network bills that are unexpected both to patients and physicians, especially in Emergency situations; and

WHEREAS, There are multiple potential legislative solutions being considered both at the national and state levels to address this problem; and

WHEREAS, Our AMA has an extensive policy addressing this issue, asking for mediation or dispute resolution mechanisms only in selected instances; **therefore be it**

RESOLVED, That the OSMA rescind 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.; and, **be it further**

RESOLVED, That the OSMA adopt its own policy similar to AMA policy H-285.904, to read as follows:

1. The OSMA adopts the following principles related to unanticipated out-of-network care:
 - A. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.
 - B. Insurers must meet appropriate network adequacy standards that include Adequate patient access to care, including access to hospital-based physician specialties. OHIO regulators should enforce such standards through active regulation of health insurance company plans.
 - C. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.
 - D. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.
 - E. Patients who are seeking emergency care should be protected under the “prudent layperson” legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.
 - F. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.

- 52 G. Minimum coverage standards for unanticipated out-of-network services should
53 be identified. Minimum coverage standards should pay out-of-network providers
54 at the usual and customary out-of-network charges for services, with the
55 definition of usual and customary based upon a percentile of all out-of-network
56 charges for the particular health care service performed by a provider in the
57 same or similar specialty and provided in the same geographical area as
58 reported by a benchmarking database. Such a benchmarking database must be
59 independently recognized and verifiable, completely transparent, independent of
60 the control of either payers or providers and maintained by a non-profit
61 organization. The non-profit organization shall not be affiliated with an insurer, a
62 municipal cooperative health benefit plan or health management organization.
63 H. Mediation and/or Independent Dispute Resolution (IDR) should be permitted in
64 all circumstances as an option or alternative to come to payment resolution
65 between insurers and providers.
66 2. The OSMA will advocate for the principles delineated in THIS POLICY for all health
67 plans, including ERISA plans.
68 3. The OSMA will advocate that any legislation addressing surprise out of network
69 medical bills use an independent, non-conflicted database of commercial charges;
70 and, **be it further**

71
72 **RESOLVED**, That the OSMA's delegation to our AMA submit a resolution at A-20 asking
73 for this amendment to Item H in their policy.
74

75 **Fiscal Note:** \$ 10,000 (Sponsor)
76 \$ 10,000 (Staff)

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 20 – 2020

Introduced by: OSMA District Two

Subject: Network Adequacy

Referred to: Resolutions Committee No. 2

WHEREAS, Many health insurers offering plans in the exchanges, Medicare Advantage, and to employers, are relying on tiered and narrow networks, which may provide patients access to lower cost plans but increasingly results in networks that are inadequate to provide meaningful access to timely, convenient and quality care; and

WHEREAS, Our AMA supports state regulators as the primary enforcer of network adequacy requirements; and

WHEREAS, The majority of the exchange plans in Ohio offer ZERO out-of-network benefits, which results in no coverage for services provided by out-of-network physicians when these patients are treated at an in-network facility; and

WHEREAS, OSMA policy supports insurers and third-party payors to reimburse patients and /or out-of-network physicians their usual charges in non-emergency care, if insurers and third-party payors are not able to arrange participating network physician care in a reasonable time; **therefore be it**

RESOLVED, That the OSMA advocate for legislation to require quarterly reporting to the Ohio Department of Insurance by health insurers on network adequacy measures; and, **be it further**

RESOLVED, That the OSMA advocate for legislation which offers financial protection to patients who seek care out-of-network when not available in-network within defined time and geographic limits; and, **be it further**

RESOLVED, That the OSMA advocate for reasonable coverage of out-of-network services when the patient does not have any choice/option for in-network services.

Fiscal Note: \$ 50,000 (Sponsor)
\$ 50,000 (Staff)

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Introduced by: Kenneth Christman, MD

Subject: Insurance and Third-Party Networks

Referred to: Resolutions Committee No. 2

WHEREAS, Such insurance and third-party payors often do not have adequate physicians and hospitals in their networks to provide medical services to those trapped in the networks; and

WHEREAS, These networks vary considerably in negotiated reimbursement rates, with small practices frequently being offered rates at or below subsistence levels; and

WHEREAS, Some insurance and third-party payors demand that payments much lower than average contracted rates be accepted as payment-in-full from non-contracted providers; and

WHEREAS, Physicians are unable to discuss fees amongst each other for fear of antitrust violations; and

WHEREAS, The large networks virtually control the marketplace as oligopolies; and

WHEREAS, Even Medicare Advantage plans and commercial Medicaid plans have instituted networks which serve no other purpose than to demand patients/subscribers to only seek medical care from those within the network; and

WHEREAS, Over 100 million Americans now obtain medical care through their self-funded ERISA employers who use third parties ONLY for using their networks and processing claims; and

WHEREAS, American workers can often obtain quality medical care at lower prices than under network conditions; and

WHEREAS, American workers would save substantially on their medical premiums and obtain medical care more efficiently without the demands of network prior authorizations and other restrictions; **therefore be it**

RESOLVED, That the OSMA study and report back on the anticompetitive and potential antitrust violations of the insurance networks, and consider possible solutions to these expensive and restrictive programs, which might include either ending the network system or the formation of physician networks in order to compensate for unbalanced negotiation tactics.

Fiscal Note: \$ 0 (Sponsor)
 \$ 20,000 (Staff)

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 22 – 2020

Introduced by: OSMA District Four

Subject: Improving the Veterans Health Administration Referrals for Veterans for Care outside the VA System

Referred to: Resolutions Committee No. 2

WHEREAS, Scandal at the Department of Veterans Affairs regarding wait times and access to referral for specialty care resulted in reforms permitting expedited referral of VA patients to doctors outside the VA system if prompt care could not be provided within the system; and

WHEREAS, A whistleblower-prompted VA internal investigation confirmed that in 2017 alone, for 2538 veterans, doctors outside the VA system were terminating services to the veterans and/or referring them to collection agencies, and impacting their credit profiles, because the VA was not providing the indicated pay for services provided; and

WHEREAS, Investigation also determined that the software system for managing travel reimbursement for the veterans referred outside the VA for care is obsolete, resulting in \$224 million in improper travel reimbursements in 2017 alone; and

WHEREAS, The House Committee on Veterans' Affairs plans a hearing this spring to address these issues; **therefore be it**

RESOLVED, That the Ohio State Medical Association advocate for reform of the Veterans Health Administration to provide timely and complete payment for veterans' care received outside the VA system and accurate and efficient management of travel reimbursement for that care; and, **be it further**

RESOLVED, That the OSMA, by means of the OSMA website, as well as written letters to elected federal legislators and the U.S. President, support actively both reform for the VA to provide timely and complete payment for care provided to veterans outside the VA system and reform for the VA to provide accurate and efficient management of veterans' travel expenses for that care.

Fiscal Note: \$ 500 (Sponsor)
\$ 1,000 (Staff)

1 OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

2
3 Resolution No. 23 – 2020

4
5 Introduced by: OSMA District Two

6
7 Subject: Government Pay for Government Mandates

8
9 Referred to: Resolutions Committee No. 2

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12
13 **WHEREAS**, Beginning in 2020, Centers for Medicare and Medicaid Services (CMS) will
14 be demanding that “providers” utilize approved “technology” using practice guidelines when
15 ordering imaging studies; and

16
17 **WHEREAS**, Such guidelines represent an unfunded mandate for physicians already
18 struggling with massive governmental regulatory burden and underpayment; and

19
20 **WHEREAS**, These technologies or “Augmented Intelligence,” are limited in their ability
21 to apply clinical context, thus limiting a physician’s ability to order appropriate testing under
22 unique circumstances and stagnating their work-flow, placing patients at risk; and

23
24 **WHEREAS**, The technology required for this mandatory decision support is extremely
25 expensive, especially for smaller and independent physician practices; **therefore be it**

26
27 **RESOLVED**, That the OSMA advocate for policies that allow for physician judgment and
28 documented medical decision-making to supersede government regulation – including the
29 utilization of Augmented Intelligence – in instances of disputes in patient care; and, **be it further**

30
31 **RESOLVED**, That the OSMA advocate for policies that require “proof of concept,” in the
32 form of independently demonstrated quality improvement, prior to the implementation of any
33 government, insurance company or other third party mandate or regulation on patient care and
34 the physician-patient relationship; and, **be it further**

35
36 **RESOLVED**, That the OSMA advocate for policies requiring government, insurance
37 company or other third party entities to fully fund any mandates or regulations imposed on
38 patient care and the physician-patient relationship; and, **be it further**

39
40 **RESOLVED**, That the OSMA delegation to our AMA write a resolution for A-20 asking
41 our AMA to advocate for similar policies.

42
43 **Fiscal Note:** \$ 10,000 (Sponsor)
44 \$ 10,000 (Staff)

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Introduced by: Kenneth Christman, MD

Subject: Determination of Inpatient/Outpatient Hospital Status

Referred to: Resolutions Committee No. 2

WHEREAS, Reliance on hospital face sheet information is often unreliable, as patients can arbitrarily be switched back and forth from inpatient to outpatient observation status; and

WHEREAS, Some physician offices are spending an inordinate amount of time with denied payments based upon arbitrary inpatient vs. outpatient hospital status; and

WHEREAS, These arbitrary changes in hospital status are requiring some physician offices to take time-consuming steps to determine hospital inpatient vs. outpatient hospital status; and

WHEREAS, Under 42 CFR 410.2, CMS defines OUTPATIENT—“means a person who has not been admitted as an inpatient but who is registered on the hospital or CAH records as an outpatient and receives services (rather than supplies alone) from the hospital or CAH.”; and

WHEREAS, Under 42 CFR 489.24, CMS defines “INPATIENT”—“means an individual who is admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services as described in 409.10 of this chapter with the expectation that he or she will remain at least overnight and occupy a bed even though the situation later develops that the individual can be discharged or transferred to another hospital and does not actually use a hospital bed overnight.” Furthermore, 42 CFR 409.10 clearly includes Bed and Board as defining “inpatient.”; and

WHEREAS, Webster's Ninth New Collegiate Dictionary definition of "inpatient" is "a hospital patient who receives lodging and food as well as treatment"; and

WHEREAS, Webster's Ninth New Collegiate Dictionary definition of "outpatient" is "a patient who is not an inmate of a hospital but who visits a clinic or dispensary connected with it for diagnosis or treatment; and

WHEREAS, Our AMA's 2016 Current Procedural Terminology (CPT Standard Edition) page xv states "Some codes have specified places of service (e.g., evaluation and management codes are specific to a setting,"; **therefore be it**

RESOLVED, That the OSMA adopt a position that requires physicians and payors to follow CMS definitions and Webster's Dictionary definition of "outpatient" vs. "inpatient" medical care (whether or not a patient is receiving food AND/OR lodging), and that payors and

physicians follow these definitions when submitting or paying for services rendered; and, **be it further**

RESOLVED, That the OSMA request the OSMA delegation to the AMA request that our AMA adopt a position that requires physicians and payors to follow CMS definitions and Webster's Dictionary definition of "outpatient" vs. "inpatient" medical care (whether or not a patient is receiving food AND/OR lodging), and that payors and physicians be required to follow these definitions when submitting or paying for services rendered.

Fiscal Note:	\$ 0 (Sponsor)
	\$ 100 (Staff)

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Introduced by: OSMA District Two

Subject: Co-Pay Accumulators

Referred to: Resolutions Committee No. 2

Fiscal Note: \$ 50,000 (Sponsor)
\$ 50,000 (Staff)

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Introduced by: Academy of Medicine of Lima and Allen County

Subject: Bundled Payments and Medically Necessary Care

Referred to: Resolutions Committee No. 2

WHEREAS, Medicaid is starting similar programs called Episodes of Care; and

WHEREAS, Some unrelated events can be very costly and cause significant spending beyond the limits of the bundle which cannot be controlled by the initial physician; and

WHEREAS, The incentive for the physicians who are caring for the patient is to save money by limiting the services that the patient receives regardless of the medical needs of the patient, because the money saved is returned to the physician; and

WHEREAS, Every patient is an individual with different responses to treatment and different co-morbidities; and

WHEREAS, Some patients need further therapy in an Inpatient Rehabilitation Unit or Skilled Nursing Facility, but are not offered those options due to cost containment; **therefore be it**

RESOLVED, That the OSMA work with Ohio Medicaid to make sure that medically necessary care is done for all patients and that Episodes of Care be carefully reviewed to make sure that the system is reasonable and fair to all, including patients and physicians; and, **be it further**

RESOLVED, That our AMA Delegation take the issue of “Bundled Payments and Medically Necessary Care” to the AMA Annual Meeting for study and report back to the AMA HOD, to make sure that our health care system is reasonable and fair to all, allows for medically appropriate and necessary care for our patients, and allows for fair reimbursement for physicians.

Fiscal Note: \$ 1,000 (Sponsor)
\$ 1,000 (Staff)

1 OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

2
3 Resolution 27 – 2020

4
5 Introduced by: OSMA Council
6
7 Subject: 2020 OSMA Policy Sunset Report
8
9 Referred to: Resolutions Committee No. 2
10

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12
13 **WHEREAS**, Chapter 4, Section 12 of the Ohio State Medical Association Constitution
14 and Bylaws provides that: any Policy adopted by the House of Delegates four (4) or more years
15 prior to each Annual Meeting will be reviewed by the Council for purposes of recommending
16 whether to retain each policy. The House of Delegates will be notified of those policies subject
17 to review prior to the Annual Meeting at which they will be considered. Any policy not retained
18 by House action on the report submitted by the Council becomes null, void and of no effect;
19 **therefore be it**

20
21 **RESOLVED**, That the recommendations of OSMA Council published prior to the Annual
22 Meeting as the 2020 OSMA Policy Sunset Report be adopted by the OSMA House of
23 Delegates.
24

25 **Ohio State Medical Association Policy Compendium Review –**
26 **2020 OSMA Policy Sunset Report**
27 **OSMA policy from years 1932 through 2016 plus Policy 23 – 2019**
28

29 *(This is a list of Policy numbers and titles. The full text of policies recommended*
30 *“**RETAIN**” as edited and “**NOT RETAIN**” is contained in this report. All other OSMA*
31 *policies will be retained as they are shown in the OSMA Policy Compendium available on*
32 *www.osma.org.)*
33

34 **Policies to be Retained as Edited:**

35
36 Policy 21 – 2015 Evidence Based Organized Medicine
37

38 **Policies to be Not Retained:**

39
40 Policy 09 – 2014 Enforcing State medical Board of Ohio Transparency
41 Policy 13 – 2014 Retail Pharmacy Participation in IMPACT SIIS
42 Policy 01 – 2015 Repeal the 2% Medicare Physician Payment Cuts Authorized by
43 Sequestration Action
44 Policy 08 – 2015 Revision of HM 314 OARRS Requirements
45 Policy 22 – 2015 Representation for Direct OSMA Members
46 Policy 26 – 2015 Delegate Appointments
47 Policy 06 – 2016 OSMA to Financially Support Physical Regional District Meetings
48 in Preparation for OSMA Annual Meeting, OSMA Constitution and
49 Bylaws Amendment – Chapter 4, Section 10

Full text of policies recommended “**RETAIN**” as Edited and “**NOT RETAIN**”

RETAIN as Edited 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.~~ 1. This OSMA committee is charged with identifying measures of success by which we can judge the impact of changes.
- ~~3.~~ 2. All members of the OSMA shall be invited to attend and participate in House of Delegates deliberations.
- ~~4.~~ 3. The OSMA shall proceed with changes to minimize the cost of the OSMA annual House of Delegates meeting.

NOT RETAIN 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.

COMMENT: Accomplished.

NOT RETAIN 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.

COMMENT: Accomplished through regulations and OHIP platform.

NOT RETAIN 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.

COMMENT: No longer an OSMA initiative.

NOT RETAIN Policy 01 – 2015 – Repeal the 2% Medicare Physician Payment Cuts Authorized by Sequestration Action

- 99 1. The OSMA shall take all necessary legislative and administrative steps to eliminate the
100 hidden 2% “sequestration” Medicare payment cuts for physicians and the Ohio Delegation to
101 the AMA shall take this policy to the AMA for action at the national level.
102

103 **COMMENT:** Accomplished.
104

105 **NOT RETAIN Policy 08 – 2015 – Revision of HB 341 OARRS Requirements**
106

- 107 1. The OSMA fully supports both policies passed by the OSMA Council regarding House Bill
108 341 of the 130th General Assembly.
109
110 2. The OSMA shall work to postpone penalties for not following the statutory and regulatory
111 query requirements from House Bill 341 of the 130th General Assembly.
112

113 **COMMENT:** Accomplished.
114

115 **NOT RETAIN Policy 22 – 2015 – Representation for Direct OSMA Members**
116

- 117 1. Direct members of the OSMA who are not members of a county society shall be invited to
118 attend the geographic District Meeting for either their office or home address and be allowed
119 to vote at that meeting.
120

121 **COMMENT:** Supplanted/superseded by 2019 OSMA Constitution and Bylaws changes.
122

123 **NOT RETAIN Policy 26 – 2015 – Delegate Appointments**
124

- 125 1. If a county does not appoint a Delegate to the OSMA House of Delegates annual meeting,
126 the District Councilor may appoint a Delegate to represent that county and that Delegate
127 can be a physician who is an OSMA member who lives in that county or a physician who is
128 an OSMA member with a satellite office in that county who regularly sees patients there and
129 is known to the physicians there, but does not live in that county.
130

131 **COMMENT:** Superseded by 2019 OSMA Constitution and Bylaws changes.
132

133 **NOT RETAIN Policy 06 – 2016 – OSMA to Financially Support Physical Regional District**
134 **Meetings in Preparation for OSMA Annual Meeting, OSMA Constitution and Bylaws**
135 **Amendment – Chapter 4, Section 10**
136

- 137 1. OSMA Bylaws Chapter 4, Section 10 be amended as follows:
138

139 The House of Delegates shall establish Councilor Districts. The districts shall comprise one
140 (1) or more contiguous counties. A district society may be organized in any of the Councilor
141 Districts to meet at such time or times as such society may fix. The OSMA shall allocate
142 funding for one physical meeting of a council district in preparation for the OSMA annual
143 meeting, if requested by the district councilor.
144

145 **COMMENT:** Superseded by 2019 Constitution and Bylaws changes.
146

NOT RETAIN 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 with 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.

COMMENT: Accomplished.

NOT RETAIN Policy 23 – 2019 – OSMA Policy Sunset Report

1. The House of Delegates adopted the recommendations of OSMA Council regarding the policies from 1932 through 2015 as is reflected in the 2019 OSMA Policy Sunset Report available on www.osma.org under Annual Meeting section. The possible actions for the policies were *Policies to be Retained*, *Policies to be Retained as Edited* and *Policies to be Not Retained*.

COMMENT: Accomplished.

Fiscal Note: \$0 (Sponsor)
\$0 (Staff)