OSMA and AMA Policies Relevant to 2024 Proposed Resolutions
Resolution Committee Two
Resolutions 19-36

Resolution 19-2024: Support for Physician Orders for Life Sustaining Treatment (POLST)

OSMA Policy

No relevant policy.

AMA Policy

AMA - D-85.992: Recognition of Physician Orders for Life Sustaining Treatment Forms

1. Our AMA will (1) work with state medical associations to advocate with appropriate legislative and regulatory bodies to recognize Physician Orders for Life Sustaining Treatment (POLST) forms completed in one state as a valid expression of a patient's directions for care; and (2) draft model state legislation and guidelines that will allow for reciprocity and/or recognition of POLST and other patient decision-making forms.

Resolution 20-2024: Adult Immunization Registry

OSMA Policy

OSMA 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.

OSMA 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.

AMA Policy

AMA - H-440.899: Immunization Registries

Our AMA encourages: (1) Physicians to participate in the development of immunization registries in their communities and use them in their practices for patients of all ages; (2) electronic health record (EHR) vendors to add features to automate the exchange of vaccination information in the patient EHR to state immunization registries to improve and help ensure completeness and accuracy of vaccination records. EHR vendors and registry administrators need to work with physicians and other health professionals to facilitate the exchange of needed vaccination information by establishing seamless, bidirectional communication capabilities for

physicians, other vaccine providers, and immunization registries; and (3) all states to move rapidly to provide comprehensive lifespan immunization registries that are interfaced with other state registries.

Resolution 21-2024: "Guarantee Issue" Protections for Traditional Medicare

OSMA Policy

No relevant policy.

AMA Policy

AMA – H-285.913: Medicare Advantage Policies
Our AMA will:
1. pursue legislation requiring that any Medicare Advantage policy sold to a Medicare patient must include a seven-day waiting period that allows for cancellation without penalty;
2. pursue legislation to require that Medicare Advantage policies carry a separate distinct page, which the patient must sign, including the statement, "THIS COVERAGE IS NOT TRADITIONAL MEDICARE. YOU HAVE CHOSEN TO CANCEL YOUR TRADITIONAL MEDICARE COVERAGE; NOT ALL PHYSICIANS, HOSPITALS AND LABORATORIES ACCEPT THIS NEW MEDICARE ADVANTAGE POLICY AND YOU MAY PERMANENTLY LOSE THE ABILITY TO PURCHASE MEDIGAP SECONDARY INSURANCE" (or equivalent statement) and specifying the time period before they can resume their traditional Medicare coverage; and
3. petition the Centers for Medicare and Medicaid Services to implement the patient's signature page in a Medicare Advantage policy.

Resolution 22-2024: Insurer Accountability When Prior Authorization Harms Patients

OSMA Policy

OSMA 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.

OSMA 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.

OSMA Policy 14-2019 - Compensation for Prior Authorization Services

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

OSMA Policy 23-2022 - Prohibit Reversal of Prior Authorization

1. The Ohio State Medical Association (OSMA) supports legislation to prohibit retroactive denial of a previously approved medication, procedure, or test unless the patient is no longer insured by that company at the time of service.
2. The OSMA delegation to the AMA will take this topic regarding reversal of prior authorization to the AMA House of Delegates to advocate for this change as a part of their greater effort to eliminate prior authorization all together.

OSMA Policy 10-2023 - Supporting Increased Access to HIV Prevention Medication

1. The OSMA opposes prior authorization requirements for HIV pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) medications.
2. The OSMA supports requiring state-regulated payers to cover full costs of HIV prevention medications and related services, including screenings, diagnostic procedures, administrative fees, and clinical follow-ups in-person or via telemedicine, without any cost-sharing obligation for the plan holder.
3. The OSMA supports legislation requiring all payers in Ohio to add long-acting injectable variations of PrEP to their formularies to ensure that they are accessible to eligible patients.

OSMA Policy 25-2023 - Codifying Efforts for Legislative Action on Prior Authorization

1. The OSMA will seek legislative solutions to reduce the burden of prior authorization requirements.
2. The OSMA advocacy team will report back annually to the House of Delegates on the status of prior authorization advocacy efforts unless deemed unnecessary by Council.

AMA Policy

AMA - H-320.939: Prior Authorization and Utilization Management Reform

1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.
4. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests.

AMA - D-320.978: Fair Reimbursement for Administrative Burdens

Our AMA will: (1) continue its strong state and federal legislative advocacy efforts to promote legislation that streamlines the prior authorization process and reduces the overall volume of prior authorizations for physician practices; (2) continue partnering with patient advocacy groups in prior authorization reform efforts to reduce patient harms, including care delays, treatment abandonment, and negative clinical outcomes; (3) oppose inappropriate payer policies and procedures that deny or delay medically necessary drugs and medical services; and (4) advocate for fair reimbursement of established and future CPT codes for administrative burdens related to (a) the prior authorization process or (b) appeals or denials of services (visits, tests, procedures, medications, devices, and claims), whether pre- or post-service denials.

AMA - D-285.960: Promoting Accountability in Prior Authorization
Our AMA will: (1) advocate that peer-to-peer (P2P) prior authorization (PA) determinations must be made and actionable at the end of the P2P discussion notwithstanding mitigating circumstances, which would allow for a determination within 24 hours of the P2P discussion; (2) advocate that the reviewing P2P physician must have the clinical expertise to treat the medical condition or disease under review and have knowledge of the current, evidence-based clinical guidelines and novel treatments; (3) advocate that P2P PA reviewers follow evidence-based guidelines consistent with national medical specialty society guidelines where available and applicable; (4) continue to advocate for a reduction in the overall volume of health plans' PA requirements and urge temporary suspension of all PA requirements and the extension of existing approvals during a declared public health emergency; (5) advocate that health plans must undertake every effort to accommodate the physician's schedule when requiring peer-to-peer prior authorization conversations; and (6) advocate that health plans must not require prior authorization on any medically necessary surgical or other invasive procedure related or incidental to the original procedure if it is furnished during the course of an operation or procedure that was already approved or did not require prior authorization.

AMA - D-320.979: Processing Prior Authorization Decisions
Our AMA will advocate that all insurance companies and benefit managers that require prior authorization have staff available to process approvals 24 hours a day, every day of the year, including holidays and weekends.

AMA - H-185.936: Lung Cancer Screening to be Considered Standard Care
Our AMA: (1) recommends that coverage of screening low-dose CT (LDCT) scans for patients at high risk for lung cancer by Medicare, Medicaid, and private insurance be a required covered benefit; (2) will empower the American public with knowledge through an education campaign to raise awareness of lung cancer screening with low-dose CT scans in high-risk patients to improve screening rates and decrease the leading cause of cancer death in the United States; and (3) will work with interested national medical specialty societies and state medical associations to urge the Centers for Medicare & Medicaid Services and state Medicaid programs to increase access to low-dose CT screening for Medicaid patients at high risk for lung cancer by including it as a covered benefit, without cost-sharing or prior authorization requirements, and increasing funding for research and education to improve awareness and utilization of the screening among eligible enrollees.

Resolution 23-2024: Eliminate Unnecessary Prior Authorization

OSMA Policy

OSMA Policy 25-2023 - Codifying Efforts for Legislative Action on Prior Authorization
The OSMA will seek legislative solutions to reduce the burden of prior authorization requirements.

The OSMA advocacy team will report back annually to the House of Delegates on the status of prior authorization advocacy efforts unless deemed unnecessary by Council.

OSMA Policy 23-2022 - Prohibit Reversal of Prior Authorization
The Ohio State Medical Association (OSMA) supports legislation to prohibit retroactive denial of a previously approved medication, procedure, or test unless the patient is no longer insured by that company at the time of service.

The OSMA delegation to the AMA will take this topic regarding reversal of prior authorization to the AMA House of Delegates to advocate for this change as a part of their greater effort to eliminate prior authorization all together.

AMA Policy

AMA – D-320.977: Utilization Review, Medical Necessity Determination, Prior Authorization Decisions
Our AMA will advocate: (a) for implementation of a federal version of a prior authorization "gold card" law, which aims to curb onerous prior authorization practices by many state-regulated health insurers and health

maintenance organizations; and (b) that health plans should offer physicians at least one physician-driven, clinically-based alternative to prior authorization, including a “gold-card” or “preferred provider program.”

AMA - H-130.971(1C): Access to Emergency Services

1. Our AMA supports the following principles regarding access to emergency services; and these principles will form the basis for continued AMA legislative and private sector advocacy efforts to assure appropriate patient access to emergency services:

(A) Emergency services should be defined as those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part.

(B) All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed emergency services to all patients, regardless of their ability to pay. (Reaffirmed by CMS Rep. 1, I-96)

(C) All health plans should be prohibited from requiring prior authorization for emergency services.

(D) Health plans may require patients, when able, to notify the plan or primary physician at the time of presentation for emergency services, as long as such notification does not delay the initiation of appropriate assessment and medical treatment.

(E) All health payers should be required to cover emergency services provided by physicians and hospitals to plan enrollees, as required under Section 1867 of the Social Security Act (i.e., medical screening examination and further examination and treatment needed to stabilize an "emergency medical condition" as defined in the Act) without regard to prior authorization or the emergency care physician's contractual relationship with the payer.

(F) Failure to obtain prior authorization for emergency services should never constitute a basis for denial of payment by any health plan or third party payer whether it is retrospectively determined that an emergency existed or not.

(G) States should be encouraged to enact legislation holding health plans and third party payers liable for patient harm resulting from unreasonable application of prior authorization requirements or any restrictions on the provision of emergency services.

(H) Health plans should educate enrollees regarding the appropriate use of emergency facilities and the availability of community-wide 911 and other emergency access systems that can be utilized when for any reason plan resources are not readily available.

(I) In instances in which no private or public third party coverage is applicable, the individual who seeks emergency services is responsible for payment for such services.

2. Our AMA will work with state insurance regulators, insurance companies and other stakeholders to immediately take action to halt the implementation of policies that violate the “prudent layperson” standard of determining when to seek emergency care.

AMA - H-320.939: Prior Authorization and Utilization Management Reform

1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.

2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.

3. Our AMA supports efforts to track and quantify the impact of health plans’ prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.

4. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests.

AMA - D-320.982: Prior Authorization Reform

Our AMA will explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior

authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens.

AMA - D-320.975: Required Clinical Qualifications in Determining Medical Diagnoses and Medical Necessity

Our American Medical Association advocates for a change to existing public and private processes including Utilization Management, Prior Authorization, Medicare and Medicaid audits, Medicare and State Public Health surveys of clinical care settings, to only allow physicians with adequate and commensurate training, scope of practice, and licensure to determine accuracy of medical diagnoses and assess medical necessity.

AMA - H-385.904(2G): Prospective Payment Model Best Practices for Independent Private Practice

1. Our AMA supports the consideration of prospective payment elements in the development of payment and delivery reform that are consistent with AMA principles.
2. Our AMA supports the following principles to support physicians who choose to participate in prospective payment models:
a. The AMA, state medical associations, and national medical specialty societies should be encouraged to continue to provide guidance and support infrastructure that allows independent physicians to join with other physicians in clinically integrated networks, independent of any hospital system.
b. Prospective payment model compensation should incentivize specialty and primary care collegiality among independently practicing physicians.
c. Prospective payment models should take into consideration clinical data, where appropriate, in addition to claims data.
d. Governance within the model must be physician-led and autonomous.
e. Physician practices should be encouraged to work with field advisors on patient attributions and a balanced mix of payers.
f. Quality metrics used in the model should be clinically meaningful and developed with physician input.
g. Administrative burdens, such as those related to prior authorization, should be reduced for participating physicians.
3. Our AMA will identify financially viable prospective payment models and develop educational opportunities for physicians to learn and collaborate on best practices for such payment models for physician practice, including but not limited to independent private practice.

AMA - H-285.904(1E): Out of Network Care

1. Our AMA 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. State 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.
G. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.
H. Independent Dispute Resolution (IDR) should be allowed in all circumstances as an option or alternative to come to payment resolution between insurers and physicians.

2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans.
3. Our AMA will advocate that any legislation addressing surprise out of network medical bills use an independent, non-conflicted database of commercial charges.

AMA - H-320.938: Prior Authorization Relief in Medicare Advantage Plans
Our AMA supports legislation and/or regulations that would apply the following processes and parameters to prior authorization (PA) for Medicaid and Medicaid managed care plans and Medicare Advantage plans:
a. List services and prescription medications that require a PA on a website and ensure that patient informational materials include full disclosure of any PA requirements.
b. Notify providers of any changes to PA requirements at least 45 days prior to change.
c. Improve transparency by requiring plans to report on the scope of PA practices, including the list of services and prescription medications subject to PA and corresponding denial, delay, and approval rates.
d. Standardize a PA request form.
e. Minimize PA requirements as much as possible within each plan and eliminate the application of PA to services and prescription medications that are routinely approved.
f. Pay for services and prescription medications for which PA has been approved unless fraudulently obtained.
g. Allow continuation of medications already being administered or prescribed when a patient changes health plans, and only change such medications with the approval of the ordering physician.
h. Make an easily accessible and responsive direct communication tool available to resolve disagreements between health plan and ordering provider.
i. Define a consistent process for appeals and grievances, including to Medicaid and Medicaid managed care plans.

Resolution 24-2024: Oversight of Health Insurance Companies

OSMA Policy

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

OSMA Policy 24-2022 - Review of Health Insurance Companies and Their Subsidiaries' Business Practices
The Ohio State Medical Association requests that our AMA delegation carry a request for AMA review of health insurance companies' business practices for potential fraudulent and unfair activities.

OSMA Policy 8-2007 - Health Insurer Interference with Physicians' Independent Medical Judgment
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.

AMA Policy

AMA - H-165.856: Health Insurance Market Regulation
Our AMA supports the following principles for health insurance market regulation:

(1) There should be greater national uniformity of market regulation across health insurance markets, regardless of type of sub-market (e.g., large group, small group, individual), geographic location, or type of health plan.

(2) State variation in market regulation is permissible so long as states demonstrate that departures from national regulations would not drive up the number of uninsured, and so long as variations do not unduly hamper the development of multi-state group purchasing alliances, or create adverse selection.
(3) Risk-related subsidies such as subsidies for high-risk pools, reinsurance, and risk adjustment should be financed through general tax revenues rather than through strict community rating or premium surcharges.
(4) Strict community rating should be replaced with modified community rating, risk bands, or risk corridors. Although some degree of age rating is acceptable, an individual's genetic information should not be used to determine his or her premium.
(5) Insured individuals should be protected by guaranteed renewability.
(6) Guaranteed renewability regulations and multi-year contracts may include provisions allowing insurers to single out individuals for rate changes or other incentives related to changes in controllable lifestyle choices.
(7) Guaranteed issue regulations should be rescinded.
(8) Health insurance coverage of pre-existing conditions with guaranteed issue within the context of an individual mandate, in addition to guaranteed renewability.
(9) Insured individuals wishing to switch plans should be subject to a lesser degree of risk rating and pre-existing conditions limitations than individuals who are newly seeking coverage.
(10) The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Specifically: (a) legislative and regulatory barriers to the formation and operation of group purchasing alliances should, in general, be removed; (b) benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options; and (c) any legislative and regulatory barriers to the development of multi-year insurance contracts should be identified and removed.

Resolution 25-2024: Opposing Take Back Payments

OSMA Policy

OSMA 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.

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

AMA Policy

AMA - H-320.943: Medicare and Insurance Takeback Procedures
Our AMA: (1) will advocate to ensure that when a patient hospitalization is retrospectively found not to meet criteria for inpatient admission, then the take back amount be only the difference between the cost of the admission and the cost of necessary observation for that patient stay; and (2) will advocate to ensure that, for any care provided to hospital patients who have Medicare, managed Medicare, or commercial insurance, hospitals have the option to rebill denied inpatient claims as outpatient claims, when a physician using clinical judgment makes a prospective decision to admit a patient who is later not found to meet admission criteria.

AMA - D-330.901: Non-Payment and Audit Takebacks by CMS
Our AMA will advocate to oppose claim nonpayment, extrapolation of overpayments, and bundled payment denials based on minor wording or clinically insignificant documentation inconsistencies.

AMA - D-385.965: Insurance Companies Use of Contractors to Recover Payments
1. Our AMA will seek legislation to limit insurance companies, their agents, or any contractors from requesting payment back on paid claims to no more than 90 days after payment is made.

(a) Such legislation would require insurance companies, their agents, or any contractors to have a defined and acceptable process for physicians to dispute these maneuvers to get payment back on claims already processed, verified, and paid.
(b) Such legislation would ban insurance companies, their agents or contractors from using re-pricers and re-reviewers and to adhere to their own pricing and reviewing guidelines as agreed upon in their contracts with physicians.
2. Our AMA will pursue legislation to regulate self-insured plans in this regard and apply the same rules to Medicare and other federal plans.

AMA - D-320.991: Creating a Fair and Balanced Medicare and Medicaid RAC Program
1. Our AMA will continue to monitor Medicare and Medicaid Recovery Audit Contractor (RAC) practices and recovery statistics and continue to encourage the Centers for Medicare and Medicaid Services (CMS) to adopt new regulations which will impose penalties against RACs for abusive practices.
2. Our AMA will continue to encourage CMS to adopt new regulations which require physician review of all medical necessity cases in post-payment audits, as medical necessity is quintessentially a physician determination and judgment.
3. Our AMA will encourage CMS to discontinue the denial of payments or imposition of negative action during an audit due to the absence of specific words in the chief complaint when the note provides adequate documentation of the reason for the visit and services rendered.
4. Our AMA will assist states by providing recommendations regarding state implementation of Medicaid RAC rules and regulations in order to lessen confusion among physicians and to ensure that states properly balance the interest in overpayment and underpayment audit corrections for Recovery Contractors.
5. Our AMA will petition CMS to amend CMS' rules governing the use of extrapolation in the RAC audit process, so that the amended CMS rules conform to Section 1893 of the Social Security Act Subsection (f) (3) - Limitation on Use of Extrapolation; and insists that the amended rules state that when an RAC initially contacts a physician, the RAC is not permitted to use extrapolation to determine overpayment amounts to be recovered from that physician by recoupment, offset, or otherwise, unless (as per Section 1893 of the Social Security Act) the Secretary of Health and Human Services has already determined, before the RAC audit, either that (a) previous, routine pre- or post-payment audits of the physician's claims by the Medicare Administrative Contractor have found a sustained or high level of previous payment errors, or that (b) documented educational intervention has failed to correct those payment errors.
6. Our AMA, in coordination with other stakeholders such as the American Hospital Association, will seek to influence Congress to eliminate the current RAC system and ask CMS to consolidate its audit systems into a more balanced, transparent, and fair system, which does not increase administrative burdens on physicians.
7. Our AMA will: (A) seek to influence CMS and Congress to require that a physician, and not a lower level provider, review and approve any RAC claim against physicians or physician-decision making, (B) seek to influence CMS and Congress to allow physicians to be paid any denied claim if appropriate services are rendered, and (C) seek the enactment of fines, penalties and the recovery of costs incurred in defending against RACs whenever an appeal against them is won in order to discourage inappropriate and illegitimate audit work by RACs.
8. Our AMA will advocate for penalties and interest to be imposed on the auditor and payable to the physician when a RAC audit or appeal for a claim has been found in favor of the physician.

AMA - H-330.921: Medicare Prepayment and Postpayment Audits
1. AMA policy is that with respect to prepayment and postpayment audits by the Medicare program, the following principles guide AMA advocacy efforts:
(a) The confidential medical record should be preserved as an instrument of clinical care, with strong confidentiality protections and, we oppose its use as an accounting document;
(b) CMS should discontinue random prepayment audits of E&M services;
(c) In lieu of prepayment audits, CMS should use focused medical review of outliers based on reviews of patterns of services, using an independent medical peer review process, where physicians practicing in the same specialty, review their peers;
(d) No financial or legal penalties should be assessed based on one level of disagreement in E&M code assignment; and

(e) CMS must stop the practice of requiring physicians to repay alleged Medicare overpayments before an actual appeal is rejected or a final administrative decision or a court order is rendered. Legislative relief will be sought if advocacy with CMS is not successful in this regard.
2. Our AMA advocates that all government recovery programs contain complete physician access to any data mining criteria and programs, that there is same-specialty/same-subspecialty physician review prior to denial of claims, and that any denial of claims be based on medical necessity review as determined by that same-specialty/same-subspecialty physician reviewer, and will explore options for increased reimbursement of physician costs related to government audits, including remedies available through the Equal Access to Justice Act.
3. Our AMA supports the enactment of federal legislation or regulation that requires fairness in the practice of conducting physicians' post-payment audits as contained in paragraph 1 above, and which would include the following:
(a) The requirement for such audits to be reviewed by a physician board certified within the same specialty prior to any requirement for repayment by the audited physician
(b) The requirement for the repayment to be placed in escrow until the appeals process is complete
(c) The removal of any incentives that are based upon a percentage of recovery for contracted government auditors
(d) The establishment of a mechanism for recovery of a practice's legal fees incurred for unsuccessful audits
(e) The full disclosure of contract terms with audit contractors
(f) The elimination or improvement of the extrapolation formula
(g) The payment for costly documentation requests
(h) Imposition of penalties on auditors for inaccurate findings, and
(i) Incentivizing the auditors to perform more physician education.
4. Our AMA will formally request that Medicare employ rules for prepayment and postpayment audits that are at least as protective as the Recovery Audit Contractor (RAC) rules for physicians, and that our AMA continue to advocate for reforms to the audit process, including giving great weight to the treating physician's determination of medical necessity.
5. Our AMA will propose to Medicare that there be a mechanism by which prepayment and postpayment audit denials can be resolved via the telephone or other electronic communications.

Resolution 26-2024: Advocating for 12-Month Continuous Medicaid Enrollment Periods to Improve Adult Health Outcomes in Ohio

OSMA Policy

OSMA 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.

OSMA 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.

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

OSMA Policy 23-2018 - Maintaining Medicaid Coverage for Group VIII Enrollees
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.

AMA Policy

AMA - H-165.832: Basic Health Program

1. Our AMA supports the adoption of 12-month continuous eligibility across Medicaid, Children's Health Insurance Program, and exchange plans to limit patient churn and promote the continuity and coordination of patient care.
2. Our AMA adopts the following principles for the establishment and operation of state Basic Health Programs:
   A. State Basic Health Programs (BHPs) should guarantee ample health plan choice by offering multiple standard health plan options to qualifying individuals. Standard health plans offered within a BHP should provide an array of choices in terms of benefits covered, cost-sharing levels, and other features.
   B. Standard health plans offered under state BHPs should offer enrollees provider networks that have an adequate number of contracted physicians and other health care providers in each specialty and geographic region.
   C. Standard health plans offered in state BHPs should include payment rates established through meaningful negotiations and contracts.
   D. State BHPs should not require provider participation, including as a condition of licensure.
   E. Actively practicing physicians should be significantly involved in the development of any policies or regulations addressing physician payment and practice in the BHP environment.
   F. State medical associations should be involved in the legislative and regulatory processes concerning state BHPs.
   G. State BHPs should conduct outreach and educational efforts directed toward physicians and their patients, with adequate support available to assist physicians with the implementation process.

AMA - H-165.839: Health Insurance Exchange Authority and Operation

1. Our American Medical Association adopts the following principles for the operation of health insurance exchanges:
   A) Health insurance exchanges should maximize health plan choice for individuals and families purchasing coverage. Health plans participating in the exchange should provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features.
   B) Any benefits standards implemented for plans participating in the exchange and/or to determine minimum creditable coverage for an individual mandate should be designed with input from patients and actively practicing physicians.
   C) Physician and patient decisions should drive the treatment of individual patients.
   D) Actively practicing physicians should be significantly involved in the development of any regulations addressing physician payment and practice in the exchange environment, which would include any regulations addressing physician payment by participating public, private or non-profit health insurance options.
   E) Regulations addressing physician participation in public, private or non-profit health insurance options in the exchange that impact physician practice should ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process.
   F) Any necessary federal authority or oversight of health insurance exchanges must respect the role of state insurance commissioners with regard to ensuring consumer protections such as grievance procedures, external review, and oversight of agent practices, training and conduct, as well as physician protections including state prompt pay laws, protections against health plan insolvency, and fair marketing practices.
2. Our AMA: (A) supports using the open marketplace model for any health insurance exchange, with strong patient and physician protections in place, to increase competition and maximize patient choice of health plans, (B) will advocate for the inclusion of actively practicing physicians and patients in health insurance exchange governing structures and against the categorical exclusion of physicians based on

conflict of interest provisions; (C) supports the involvement of state medical associations in the legislative and regulatory processes concerning state health insurance exchanges; and (D) will advocate that health insurance exchanges address patient churning between health plans by developing systems that allow for real-time patient eligibility information.

Resolution 27-2024: Opposing Involuntary Surgeries on Intersex Youth and Infants

OSMA Policy

OSMA 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.

AMA Policy

AMA - H-470-951: Opposition to Requirements for Gender-Based Treatments for Athletes
Our AMA opposes: (1) mandatory testing, medical treatment or surgery for transgender athletes and athletes with Differences of Sex Development (DSD), and affirm that these athletes be permitted to compete in alignment with their identity; (2) the use of specific hormonal guidelines to determine gender classification for athletic competitions; and (3) satisfying third-party requirements to certify or confirm an athlete's gender through physician participation.

AMA - H-60.945: Neonatal Male Circumcision

1. Our AMA: (a) encourages training programs for pediatricians, obstetricians, and family physicians to incorporate information on the use of local pain control techniques for neonatal circumcision; (b) supports that evaluation of current evidence indicates that the health benefits of newborn male circumcision outweigh the risks and that the procedure's benefits justify access to this procedure for families who choose it. Specific benefits identified included prevention of urinary tract infections, penile cancer, and transmission of some sexually transmitted infections, including HIV. and (c) urges that as part of the informed consent discussion, the risks and benefits of pain control techniques for circumcision be thoroughly discussed to aid parents in making their decisions.
2. Our AMA encourages state Medicaid reimbursement of neonatal male circumcision.

AMA-MSS Policy 245.020: Supporting Autonomy for Intersex Patients and Patients with Differences of Sex Development (June 2021)
RESOLVED, That our AMA-MSS amend 245.020MSS as follows:
Supporting Autonomy for Intersex Patients and Patients with Differences of Sex Development
AMA-MSS will ask that our AMA affirm that medically unnecessary surgeries in intersex patients and individuals born with differences of sex development are unethical and should be avoided until the patient can actively participate in decision-making.

Resolution 28-2024: Opposition to Requirements for Gender-Based Treatment for Athletes

OSMA Policy

No relevant policy.

AMA Policy

AMA - H-470.951: Opposition to Requirements for Gender-Based Treatments for Athletes
Our AMA opposes: (1) mandatory testing, medical treatment or surgery for transgender athletes and athletes with Differences of Sex Development (DSD), and affirm that these athletes be permitted to compete in alignment with their identity; (2) the use of specific hormonal guidelines to determine gender classification for athletic competitions; and (3) satisfying third-party requirements to certify or confirm an athlete's gender through physician participation.

Resolution 29-2024: Firearm Safety for Civilians and Law Enforcement

OSMA Policy

OSMA Policy 54-1989 - Waiting Period before Gun Purchase
The OSMA supports a waiting period of at least one week before purchasing any form of firearm in the state of Ohio.

AMA Policy

AMA - H-145.996: Firearm Availability
1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.
2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.
3. Our AMA supports "gun violence restraining orders" for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as "red-flag" laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and "red-flag" laws, we also support the importance of due process so that individuals can petition for their rights to be restored.
4. Our AMA advocates for (a) federal and state policies that prevent inheritance, gifting, or transfer of ownership of firearms without adhering to all federal and state requirements for background checks, waiting periods, and licensure; (b) federal and state policies to prevent "multiple sales" of firearms, defined as the sale of multiple firearms to the same purchaser within five business days; and (c) federal and state policies implementing background checks for ammunition purchases.

AMA - H-145.983: School Violence
Our AMA: (1) encourages states to adopt legislation enabling schools to limit and control the possession and storage of weapons or potential weapons on school property; (2) advocates for schools to remain gun-free zones except for school-sanctioned activities and professional law enforcement officers; and (3) opposes requirements or incentives of teachers to carry weapons.

AMA - D-145.992: Further Action to Respond to the Gun Violence Public Health Crisis
Our AMA will (a) make readily accessible on the AMA website the comprehensive summary of AMA policies, plans, current activities, and progress regarding the public health crisis of firearm violence; (b) establish a task force to focus on gun violence prevention including gun-involved suicide; (c) support and consider providing grants to evidence-based firearm violence interruption programs in communities, schools, hospitals, and clinics; (d) collaborate with interested state and specialty societies to increase engagement in litigation related to firearm safety; and (e) report annually to the House of Delegates on our AMA's efforts relating to legislation, regulation, and litigation at the federal, state, and local levels to prevent gun violence.

Resolution 30-2024: Obesity as a Public Health Emergency

OSMA Policy

OSMA Policy 11-2022 - Addressing Weight Stigma Among Healthcare Workers

1. The Ohio State Medical Association (OSMA) supports health promotion techniques that center around healthy behavior and lifestyle modifications rather than weight reduction alone.
2. The OSMA supports educational training to further educate healthcare practitioners and trainees about the multifactorial nature of body weight, the impact of weight stigma, and strategies to reduce the detrimental health effects of weight stigma on Ohioans.

OSMA 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.

AMA Policy

AMA - D-440.954: Addressing Adult and Pediatric Obesity

1. Our AMA will: (a) assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; (b) encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; and (c) continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention.
2. Our AMA, consistent with H-440.842, Recognition of Obesity as a Disease, will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions).
3. Our AMA will work with interested national medical specialty societies and state medical associations to increase public insurance coverage of and payment for the full spectrum of evidence-based adult and pediatric obesity treatment.
4. Our AMA will: (a) work with state and specialty societies to identify states in which physicians are restricted from providing the current standard of care with regards to obesity treatment; and (b) work with interested state medical societies and other stakeholders to remove out-of-date restrictions at the state and federal level prohibiting healthcare providers from providing the current standard of care to patients affected by obesity.
5. Our AMA will leverage existing channels within AMA that could advance the following priorities:
   · Promotion of awareness amongst practicing physicians and trainees that obesity is a treatable chronic disease along with evidence-based treatment options.
   · Advocacy efforts at the state and federal level to impact the disease obesity.
   · Health disparities, stigma and bias affecting people with obesity.
   · Lack of insurance coverage for evidence-based treatments including intensive lifestyle intervention, anti-obesity pharmacotherapy and bariatric and metabolic surgery.
   · Increasing obesity rates in children, adolescents and adults.
   · Drivers of obesity including lack of healthful food choices, over-exposure to obesogenic foods and food marketing practices.
6. Our AMA will conduct a landscape assessment that includes national level obesity prevention and treatment initiatives, and medical education at all levels of training to identify gaps and opportunities where AMA could demonstrate increased impact.

7. Our AMA will convene an expert advisory panel once, and again if needed, to counsel AMA on how best to leverage its voice, influence and current resources to address the priorities listed in item 5. above.

AMA - H-440-902: Obesity as a Major Health Concern
The AMA: (1) recognizes obesity in children and adults as a major public health problem; (2) will study the medical, psychological and socioeconomic issues associated with obesity, including reimbursement for evaluation and management of patients with obesity; (3) will work with other professional medical organizations, and other public and private organizations to develop evidence-based recommendations regarding education, prevention, and treatment of obesity; (4) recognizes that racial and ethnic disparities exist in the prevalence of obesity and diet-related diseases such as coronary heart disease, cancer, stroke, and diabetes and recommends that physicians use culturally responsive care to improve the treatment and management of obesity and diet-related diseases in minority populations; and (5) supports the use of cultural and socioeconomic considerations in all nutritional and dietary research and guidelines in order to treat patients affected by obesity.

AMA - D-440-980: Recognizing and Taking Action in Response to the Obesity Crisis
Our AMA will: (1) advocate for the creation of a multidisciplinary federal task force, including representation from the medical profession, to review the public health impact of obesity and recommend measures to: (a) better recognize and treat obesity as a chronic disease; and (b) confront the epidemic of obesity and its root causes, particularly among populations with disproportionally high incidence; (2) actively pursue, in collaboration and coordination with programs and activities of appropriate agencies and organizations, the creation of a "National Obesity Awareness Month"; (3) strongly encourage through a media campaign the re-establishment of meaningful physical education programs in primary and secondary education as well as family-oriented education programs on obesity prevention; (4) promote the inclusion of education on obesity prevention and the medical complications of obesity in medical school and appropriate residency curricula; and (5) make Council on Medical Education Report 3, A-17, Obesity Education, available on the AMA website for use by medical students, residents, teaching faculty, and practicing physicians.

AMA - H-440-842: Recognition of Obesity as a Disease
Our AMA recognizes obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention.

AMA - 150-953: Obesity as a Major Public Health Problem
Our AMA will: (1) urge physicians as well as managed care organizations and other third party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions;

(2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs;

(3) urge federal support of research to determine: (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the effectiveness of weight loss counseling by physicians;

(4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight;

(5) urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated,

physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity;

(6) urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain;

(7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients;

(8) urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity; and

(9) urge all payers to ensure coverage parity for evidence-based treatment of obesity, including FDA-approved medications without exclusions or additional carve-outs.

AMA - H-170.961: Prevention of Obesity Through Instruction in Public Schools
Our AMA will urge appropriate agencies to support legislation that would require meaningful yearly instruction in nutrition, including instruction in the causes, consequences, and prevention of obesity, in grades 1 through 12 in public schools and will encourage physicians to volunteer their time to assist with such an effort.

AMA - 440.800: Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders
1. Our AMA recognizes: (1) the issues with using body mass index (BMI) as a measurement because: (a) of the historical harm of BMI, (b) of the use of BMI for racist exclusion, and (c) BMI cutoffs for underweight, normal, overweight, and obesity are based primarily on health risks in non-Hispanic White populations. (2) the significant limitations associated with the widespread use of BMI in clinical settings and suggests its use be in a conjunction with other valid measures of risk such as, but not limited to, measurements of: (a) visceral fat, (b) body adiposity index, (c) body composition, (d) relative fat mass, (e) waist circumference and (f) genetic/metabolic factors. (3) that BMI is significantly correlated with the amount of fat mass in the general population but loses predictability when applied on the individual level. (4) that relative body shape and composition heterogeneity across race/ethnic groups, sexes, genders, and age-span is essential to consider when applying BMI as a measure of adiposity. (5) that in some diagnostic circumstances, the use of BMI should not be used as a sole criterion for appropriate insurance reimbursement. (6) that in some clinical circumstances BMI may have utility and that BMI > 35 should continue to be used for risk stratification. (7) that BMI is a useful tool for population level surveillance of obesity trends due to its ease of use and low risk for application inconstancies. (8) that BMI is useful as an initial screener for metabolic health risks.
2. Our AMA supports further research on the application of the extended BMI percentiles and z-scores and its association with other anthropometric measurements, risk factors, and health outcomes.
3. Our AMA supports efforts to educate physicians on the issues with BMI and alternative measures for diagnosing obesity.

AMA - H-440.866: The Clinical Utility of Measuring Body Mass Index, Body Composition, Adiposity, and Waist Circumference in the Diagnosis and Management of Adult Overweight and Obesity
Our AMA supports: (1) greater emphasis in physician educational programs on the risk differences within and between demographic groups at varying levels of adiposity, BMI, body composition, and waist circumference and the importance of monitoring these in all individuals; (2) additional research on the efficacy of screening for overweight and obesity, using different indicators, in improving various clinical outcomes across populations, including morbidity, mortality, mental health, and prevention of further weight gain; and (3) more research on the efficacy of screening and interventions by physicians to promote healthy lifestyle behaviors, including healthy diets and regular physical activity, in all of their patients to improve health and minimize disease risks.

AMA - H-150.944: Combating Obesity and Health Disparities
Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful dairy and nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of foods and beverages low in fat, added sugars, and cholesterol.

Resolution 31-2024: Supporting Programs and Policies to Address Disparities in Maternal and Infant Morbidity and Mortality in Ohio

OSMA Policy

OSMA Policy 20-2023 - Utilizing Principles of Collective Impact to Address Pregnancy-Related Mortality in Ohio

1. Our OSMA supports legislation and government action that works to foster research and/or directly affect maternal mortality rates in the state of Ohio
2. Our OSMA collaborate with Ohio Pregnancy Associated Mortality Review and Ohio Council to Advance Maternal Health to address pregnancy related morbidity and mortality in Ohio
3. Our OSMA collaborate with healthcare facilities and other relevant stakeholders to support the development of resources to train healthcare providers in identification and referral of patients for participation in community health pregnancy-related morbidity and mortality programs.

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

1. The OSMA shall 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

OSMA 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.

AMA Policy

AMA - D-420.993: Disparities in Maternal Mortality

Our AMA: (1) will ask the Commission to End Health Care Disparities to evaluate the issue of health disparities in maternal mortality and offer recommendations to address existing disparities in the rates of maternal mortality in the United States; (2) will work with the CDC, HHS, state and county health departments to decrease maternal mortality rates in the US; (3) encourages and promotes to all state and county health departments to develop, implement, and sustain a maternal mortality surveillance system that centers around health equity; and (4) will work with stakeholders to encourage research on identifying barriers and developing strategies toward the implementation of evidence-based practices to prevent disease conditions that contribute to poor obstetric outcomes, maternal morbidity and maternal mortality in racial and ethnic minorities.

AMA - D-245.994: Infant Mortality

1. Our AMA will work with appropriate agencies and organizations towards reducing infant mortality by providing information on safe sleep positions and preterm birth risk factors to physicians, other health professionals, parents, and child care givers.

2. Our AMA will work with Congress and the Department of Health and Human Services to improve maternal outcomes through: (a) maternal/infant health research at the NIH to reduce the prevelance of premature births and to focus on obesity research, treatment and prevention; (b) maternal/infant health research and surveillance at the CDC to assist states in setting up maternal mortality reviews; modernize state birth and death records systems to the 2003-recommended guidelines; and improve the Safe Motherhood Program; (c) maternal/infant health programs at HRSA to improve the Maternal Child Health Block grant; (d) comparitive effectiveness research into the interventions for preterm birth; (e) disparities research into maternal outcomes, preterm birth and pregnancy-related depression; and (f) the development, testing and implementation of quality improvement measures and initiatives.

AMA - H-60.909: State Maternal Mortality Review Committees
Our AMA supports: (1) the important work of maternal mortality review committees; (2) work with state and specialty medical societies to advocate for state and federal legislation establishing Maternal Mortality Review Committees; and (3) work with state and specialty medical societies to secure funding from state and federal governments that fully supports the start-up and ongoing work of state Maternal Mortality Review Committees.

AMA - H-185.917: Reducing Inequities and Improving Access to Insurance for Maternal Health Care
1. Our AMA acknowledges that structural racism and bias negatively impact the ability to provide optimal health care, including maternity care, for people of color.
2. Our AMA encourages physicians to raise awareness among colleagues, residents and fellows, staff, and hospital administrators about the prevalence of racial and ethnic inequities and the effect on health outcomes, work to eliminate these inequities, and promote an environment of trust.
3. Our AMA encourages physicians to pursue educational opportunities focused on embedding equitable, patient-centered care for patients who are pregnant and/or within 12 months postpartum into their clinical practices and encourages physician leaders of health care teams to support similar appropriate professional education for all members of their teams.
4. Our AMA will continue to monitor and promote ongoing research regarding the impacts of societal (e.g., racism or unaffordable health insurance), geographical, facility-level (e.g., hospital quality), clinician-level (e.g., implicit bias), and patient-level (e.g., comorbidities, chronic stress or lack of transportation) barriers to optimal care that contribute to adverse and disparate maternal health outcomes, as well as research testing the effectiveness of interventions to address each of these barriers.
5. Our AMA will promote the adoption of federal standards for clinician collection of patient-identified race and ethnicity information in clinical and administrative data to better identify inequities. The federal data collection standards should be: (a) informed by research (including real-world testing of technical standards and standardized definitions of race and ethnicity terms to ensure that the data collected accurately reflect diverse populations and highlight, rather than obscure, critical distinctions that may exist within broad racial or ethnic categories), (b) carefully crafted in conjunction with clinician and patient input to protect patient privacy and provide non-discrimination protections, and (c) lead to the dissemination of best practices to guide respectful and non-coercive collection of accurate, standardized data relevant to maternal health outcomes.
6. Our AMA supports the development of a standardized definition of maternal mortality and the allocation of resources to states and Tribes to collect and analyze maternal mortality data (i.e., Maternal Mortality Review Committees and vital statistics) to enable stakeholders to better understand the underlying causes of maternal deaths and to inform evidence-based policies to improve maternal health outcomes and promote health equity.
7. Our AMA encourages hospitals, health systems, and state medical associations and national medical specialty societies to collaborate with non-clinical community organizations with close ties to minoritized and other at-risk populations to identify opportunities to best support pregnant persons and new families.
8. Our AMA encourages the development and funding of resources and outreach initiatives to help pregnant individuals, their families, their communities, and their workplaces to recognize the value of comprehensive prepregnancy, prenatal, peripartum, and postpartum care. These resources and initiatives should encourage patients to pursue both physical and behavioral health care, strive to reduce barriers to pursuing care, and highlight care that is available at little or no cost to the patient.
9. Our AMA supports adequate payment from all payers for the full spectrum of evidence-based prepregnancy, prenatal, peripartum, and postpartum physical and behavioral health care.
10. Our AMA encourages hospitals, health systems, and states to participate in maternal safety and quality improvement initiatives such as the Alliance for Innovation on Maternal Health program and state perinatal quality collaboratives.
11. Our AMA will advocate for increased access to risk-appropriate care by encouraging hospitals, health systems, and states to adopt verified, evidence-based levels of maternal care.

Resolution 32-2024: Supporting Expanded Naloxone Availability and Training and Encouraging Mandated Access in Public Institutions

OSMA Policy

OSMA Policy 8-2023 - Reducing Barriers and Eliminating Disparities Surrounding Use of Medications for Opioid Use Disorder in Ohio

1. OSMA Policy 13-2022 - curbing opioid-related deaths in Ohio through medication-assisted treatment and harm reduction services be amended to read as follows:
2. The Ohio State Medical Association (OSMA) advocates for the use of medication-assisted treatment, including but not limited to methadone or buprenorphine, and harm reduction methods without penalty when clinically appropriate.
3. The OSMA supports public awareness campaigns to increase education of evidence-based services for opioid addiction, including but not limited to medication-assisted treatment, harm reduction, and recovery services.
4. The OSMA supports existing and pilot programs for the distribution of fentanyl test strips in at-risk communities in Ohio.
5. The OSMA supports legislation prohibiting prior authorization requirements and other restrictions on use of evidence-based medications for opioid use disorder.
6. The OSMA supports research, policy, and education concerning the impacts of racism and classism on patient awareness of and access to substance use disorder treatment.

AMA Policy

AMA - H-95.932: Increasing Availability of Naloxone and Other Safe and Effective Overdose Reversal Medications

1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone and other safe and effective overdose reversal medications, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone and other safe and effective overdose reversal medications delivery.
2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone and other safe and effective overdose reversal medications .
3. Our AMA encourages physicians to co-prescribe naloxone and other safe and effective overdose reversal medications to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.
4. Our AMA encourages private and public payers to include all forms of naloxone and other safe and effective overdose reversal medications on their preferred drug lists and formularies with minimal or no cost sharing.
5. Our AMA supports liability protections for physicians and other healthcare professionals and others who are authorized to prescribe, dispense and/or administer naloxone and other safe and effective overdose reversal medications pursuant to state law.
6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone and other safe and effective overdose reversal medications to receive appropriate education to enable them to do so effectively.
7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone and other safe and effective overdose reversal medications with the Food and Drug Administration.
8. Our AMA supports the widespread implementation of easily accessible naloxone and other safe and effective overdose reversal medications rescue stations (public availability of naloxone and other safe and effective overdose reversal medications through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators.
9. Our AMA supports the legal access to and use of naloxone and other safe and effective overdose reversal medications in all public spaces regardless of whether the individual holds a prescription.
10. Our AMA supports efforts to increase the availability, delivery, possession and use of mail-order overdose reversal medications, including naloxone, to help prevent opioid-related overdose, especially in vulnerable populations, including but not limited to underserved communities and American Indian reservation populations.

Resolution 33-2024: Expanding Access to Opioid Agonist Therapies with Associated Trained Medical Personnel in Rehabilitation Facilities

OSMA Policy

OSMA Policy 13-2022 - Curbing Opioid-Related Deaths in Ohio Through Medication-Assisted Treatment and Harm Reduction Services

1. The Ohio State Medical Association (OSMA) advocates for the use of medication-assisted treatment, including but not limited to methadone or buprenorphine, and harm reduction methods without penalty when clinically appropriate.
2. The OSMA supports public awareness campaigns to increase education of evidence-based services for opioid addiction, including but not limited to medication-assisted treatment, harm reduction, and recovery services.
3. The OSMA supports existing and pilot programs for the distribution of fentanyl test strips in at-risk communities in Ohio.
4. The OSMA supports legislation prohibiting prior authorization requirements and other restrictions on use of evidence-based medications for opioid use disorder.
5. The OSMA supports research, policy, and education concerning the impacts of racism and classism on patient awareness of and access to substance use disorder treatment.

OSMA Policy 8-2023 - Reducing Barriers and Eliminating Disparities Surrounding Use of Medications for Opioid Use Disorder in Ohio

OSMA Policy 13-2022 - curbing opioid-related deaths in Ohio through medication-assisted treatment and harm reduction services be amended to read as follows:

1. The Ohio State Medical Association (OSMA) advocates for the use of medication-assisted treatment, including but not limited to methadone or buprenorphine, and harm reduction methods without penalty when clinically appropriate.
2. The OSMA supports public awareness campaigns to increase education of evidence-based services for opioid addiction, including but not limited to medication-assisted treatment, harm reduction, and recovery services.
3. The OSMA supports existing and pilot programs for the distribution of fentanyl test strips in at-risk communities in Ohio.
4. THE OSMA SUPPORTS LEGISLATION PROHIBITING PRIOR AUTHORIZATION REQUIREMENTS AND OTHER RESTRICTIONS ON USE OF EVIDENCE-BASED MEDICATIONS FOR OPIOID USE DISORDER.
5. THE OSMA SUPPORTS RESEARCH, POLICY, AND EDUCATION CONCERNING THE IMPACTS OF RACISM AND CLASSISM ON PATIENT AWARENESS OF AND ACCESS TO SUBSTANCE USE DISORDER TREATMENT.

AMA Policy

AMA - D-95.972: Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder

1. Our AMA's Opioid Task Force will publicize existing resources that provide advice on overcoming barriers and implementing solutions for prescribing buprenorphine for treatment of Opioid Use Disorder.
2. Our AMA supports eliminating the requirement for obtaining a waiver to prescribe buprenorphine for the treatment of opioid use disorder.
3. Our AMA supports patients' ability to receive buprenorphine doses that exceed dosage limits listed in FDA-approved labeling when recommended by their prescriber for the treatment of opioid use disorder.
4. Our AMA urges interested parties, including federal agencies, manufacturers, medical organizations, and health plans to review the evidence concerning buprenorphine dosing and revise labels and policies accordingly, in light of increasing mortality related to high-potency synthetic opioids.

AMA - D-95.968: Support the Elimination of Barriers to Evidence-Based Treatment for Substance Use Disorders
1. Our AMA will: (a) advocate for legislation that eliminates barriers to, increases funding for, and requires access to all appropriate FDA-approved medications or therapies used by licensed drug treatment clinics or facilities; and (b) develop a public awareness campaign to increase awareness that medical treatment of substance use disorder with medications for opioid use disorder (MOUD) and other evidence-based options as first-line treatments for this chronic medical disease.
2. Our AMA will support further research into how primary care practices can implement MOUD into their practices and disseminate such research in coordination with primary care specialties.
3. The AMA Substance Use and Pain Care Task Force will increase its evidence-based educational resources focused on methadone maintenance therapy (MMT) and publicize those resources to the Federation.
4. Our AMA will support increased access to affordable, accessible transportation for individuals to obtain evidence-based treatment for substance use disorders.

Resolution 34-2024: Encourage Marijuana Counseling and Harm Reduction

OSMA Policy

No relevant policy.

AMA Policy

No relevant policy.

Resolution 35-2024: Increasing Awareness of Harmful Algal Bloom Toxicity

OSMA Policy

OSMA Policy 12-2023 - Supporting Environmental Sustainability in Hospitals and Physician Offices
The OSMA (1) supports initiatives to promote environmental sustainability by healthcare facilities and entities across Ohio, and (2) supports physicians seeking to adopt programs for environmental sustainability in their practices.

OSMA Policy 7-2023 - Establishing Support for the Regulation of Endocrine Disrupting Chemicals in Food, Agricultural, and Household Products
OSMA supports the investigation and regulation of the use of endocrine-disrupting chemicals in food, agricultural, and household products.

OSMA Policy 24-2010 - Updating of the Safe Drinking Water Act
(reaffirmed at the 2019 OSMA House of Delegates)
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.

OSMA 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.

OSMA Policy 27-2022 - Recognition of Climate Change as a Threat to Ohio's Health
1. The OSMA encourages the development of policy to combat climate change and its health effects in Ohio and to mitigate the undesirable environmental conditions that damage Ohioans' health. 2. The OSMA encourages education of the broader Ohio medical community to the serious adverse health effects of climate change and local conditions of climate variation.

AMA Policy

AMA - H-135.939: Green Initiatives and the Health Care Community

Our AMA supports: (1) responsible waste management and clean energy production policies that minimize health risks, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; (5) the establishment, expansion, and continued maintenance of affordable, accessible, barrier-free, reliable, and clean-energy public transportation; and (6) community-wide adoption of 'green' initiatives and activities by organizations, businesses, homes, schools, and government and health care entities.

AMA - H-135.928: Safe Drinking Water

Our AMA supports updates to the U.S. Environmental Protection Agency's Lead and Copper Rule as well as other state and federal laws to eliminate exposure to lead through drinking water by:
(1) Removing, in a timely manner, lead service lines and other leaded plumbing materials that come into contact with drinking water;
(2) Requiring public water systems to establish a mechanism for consumers to access information on lead service line locations;
(3) Informing consumers about the health-risks of partial lead service line replacement;
(4) Requiring the inclusion of schools, licensed daycare, and health care settings among the sites routinely tested by municipal water quality assurance systems;
(5) Creating and implementing standardized protocols and regulations pertaining to water quality testing, reporting and remediation to ensure the safety of water in schools and child care centers;
(6) Improving public access to testing data on water lead levels by requiring testing results from public water systems to be posted on a publicly available website in a reasonable timeframe thereby allowing consumers to take precautions to protect their health;
(7) Establishing more robust and frequent public education efforts and outreach to consumers that have lead service lines, including vulnerable populations;
(8) Requiring public water systems to notify public health agencies and health care providers when local water samples test above the action level for lead;
(9) Seeking to shorten and streamline the compliance deadline requirements in the Safe Drinking Water Act; and
(10) Actively pursuing changes to the federal lead and copper rules consistent with this policy.

AMA - H-135.934: EPA and Green House Gas Regulation

1. Our AMA supports the Environmental Protection Agency's authority to promulgate rules to regulate and control green house gas emissions in the United States.
2. Our AMA: (a) strongly supports evidence-based environmental statutes and regulations intended to regulate air and water pollution and to reduce greenhouse gas emissions; and (b) will advocate that environmental health regulations should only be modified or rescinded with scientific justification.

AMA - H-135.943: Expansion of Hazardous Waste Landfills Over Aquifers

Our AMA:
(1) recognizes that the expansion of hazardous waste landfills or the construction of new hazardous waste landfills over principal aquifers represents a potential health risk for the public water supply and is inconsistent with sound principles of public health policy, and therefore should be opposed;
(2) will advocate for the continued monitoring of groundwater sources, including principal aquifers, that may be contaminated by hazardous waste landfill or other landfill leachate; and
(3) supports efforts to improve hazardous waste treatment, recycling, and disposal methods in order to reduce the public health burden.

Resolution 36-2024: Support for Environmental Justice Initiatives

OSMA Policy

OSMA Policy 27-2022 - Recognition of Climate Change as a Threat to Ohio's Health
1. The OSMA encourages the development of policy to combat climate change and its health effects in Ohio and to mitigate the undesirable environmental conditions that damage Ohioans' health.
2. The OSMA encourages education of the broader Ohio medical community to the serious adverse health effects of climate change and local conditions of climate variation.

OSMA 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.

AMA Policy

AMA - D-135.997: Environmental Contributors to Disease and Advocating for Environmental Justice
Our AMA will (1) advocate for the greater public and private funding for research into the environment causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease; (2) ask the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease and environmental racism as a priority public health issues; (3) encourage federal, state, and local agencies to address and remediate environmental injustice, environmental racism, and all other environmental conditions that are adversely impacting health, especially in marginalized communities; and (4) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies.

AMA - H-65.952: Racism as a Public Health Threat
1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
4. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
5. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

AMA H-135.911: Environmental Health Equity in Federally Subsidized Housing
1. Our American Medical Association acknowledges the potential adverse health impacts of living in close proximity to Superfund sites or other contaminated lands.
2. Our AMA advocates for mandated disclosure of Superfund sites or other contaminated lands proximity to those purchasing, leasing, or currently residing in housing in close proximity to Superfund sites or other contaminated lands.
3. Our AMA supports efforts of public agencies to study the safety of proposed public housing expansions with respect to pollutant exposure and to expand construction of new public and publicly subsidized housing properties on lands without demonstrated unsafe levels of hazardous pollutants.

AMA - H-135.973: Stewardship of the Environment
The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate

in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation.(12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues;
(15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support.

AMA - H-135.969: Environmental Health Programs
Our AMA (1) urges the physicians of the United States to respond to the challenge for a clean environment individually and through professional groups by becoming the spokespersons for environmental stewardship; and (2) encourages state and county medical societies to establish active environmental health committees.