Handbook Review: HOD Reference Committee J (medical service, medical practice, insurance)

Full text at https://www.ama-assn.org/sites/default/files/media-browser/public/hod/i18-refcomm-j.pdf. Recommended positions: Support, Active Support, Oppose, Active Oppose, Monitor

HOD resolution or report (sponsor)	Action requested	AMA-YPS recommended position
BOT Report 9: Hospital Closures and Physician Credentialing (Resolution 716-A-18)	The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 716-A-18 and that the remainder of the report be filed: 1. That our American Medical Association (AMA) reaffirm Policy H-230.956, which states that the governing body of the hospital, ambulatory surgery facility, nursing home, or other health care facility should be responsible for making arrangements for the disposition of physician credentialing records upon the closing of a facility and should make appropriate arrangements so that each physician will have the opportunity to make a timely request to obtain a copy of the verification of his/her credentials, clinical privileges, and medical staff status. (Reaffirm HOD Policy) 2. That our AMA develop model state legislation and regulations that would require hospitals to: (a) implement a procedure for preserving medical staff credentialing files in the event of the closure of the hospital; and (b) provide written notification to its state health agency and medical staff before permanently closing its facility indicating whether arrangements have been made for the timely transfer of credentialing files and the exact location of those files. (Directive to Take Action) 3. That our AMA: (a) continue to monitor the development and implementation of physician credentialing repository databases that track hospital affiliations; and (b) explore the feasibility of developing a universal clearinghouse that centralizes the verification of credentialing information as it relates to physician practice and affiliation history, and report back to the House of Delegates at the 2019 Interim Meeting. (Directive to Take Action) Fiscal Note: Modest – Between $1,000 and $5,000	Support
CMS Report 1: Prescription Drug Importation for Personal Use (Resolution 226-I-17)	The Council on Medical Service recommends that the following be adopted in lieu of Resolution 226-I-17, and that the remainder of the report be filed. 1. That our American Medical Association (AMA) support the in-person purchase and importation of prescription drugs obtained directly from a licensed Canadian pharmacy when product integrity can be assured, provided such drugs are for personal use and of a limited quantity. (New HOD Policy) 2. That our AMA advocate for an increase in funding for the US Food and Drug Administration to administer and enforce a program that allows the in-person purchase and importation of prescription drugs from Canada, if the integrity of prescription drug products imported for	Support

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	personal use can be assured. (New HOD Policy) 3. That our AMA reaffirm Policy D-100.983, which outlines criteria for supporting the legalized importation of prescription drug products by wholesalers and pharmacies, and opposes the personal importation of prescription drugs via the Internet until patient safety can be assured. (Reaffirm HOD Policy) 4. That our AMA reaffirm Policy D-100.985, which opposes the illegal importation of prescription drugs and drug counterfeiting, and supports working with Congress, federal agencies and other stakeholders to ensure that these illegal activities are minimized. (Reaffirm HOD Policy) Fiscal Note: Less than $500	
CMS Report 2: Subject: Air Ambulance Regulations and Payments	The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed: 1. That our American Medical Association 1 (AMA) amend Policy, H-130.954, "Non-Emergency Patient Transportation Systems," by addition as follows: The AMA: (1) supports the education of physicians, first responders, and the public about the costs associated with inappropriate use of emergency patient transportation systems; and (2) encourages the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients. (Modify Current HOD Policy) 2. That our AMA support increased data collection and data transparency of air ambulance providers and services to the appropriate state and federal agencies, particularly increased price transparency. (New HOD Policy) 3. That our AMA work with relevant stakeholders to evaluate the Airline Deregulation Act as it applies to air ambulances. (New HOD Policy) 4. That our AMA support stakeholders sharing air ambulance best practices across regions. (New HOD Policy) 5. That our AMA rescind Policy D-130.964, which directed the AMA to conduct the study herein. (Rescind AMA Policy) Fiscal Note: Less than $500.	Support
*CMS Report 3: Sustain Patient-	RECOMMENDATIONS The Council on Medical Service recommends that the following be adopted in lieu of Resolution	Support

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Centered Medical Home Practices (Resolution 813-I-17)	813-I-17 and that the remainder of the report be filed: 1. That our American Medical Association (AMA) reaffirm Policy H-160.919 that contains principles of the Patient-Centered Medical Home (PCMH) including that payment should appropriately recognize the added value provided to patients who have a PCMH and the additional physician and team work associated with participating in a PCMH. (Reaffirm HOD Policy) 2. That our AMA reaffirm Policy H-385.908 urging that financial risk should be limited to costs that physicians have the ability to influence or control. (Reaffirm HOD Policy) 3. That our AMA amend Policy, H-160.918, "The Patient-Centered Medical Home," by addition and deletion as follows: Our AMA: a. will urge the Centers for Medicare and Medicaid Services (CMS) to work with our AMA and national medical specialty societies to design incentives to enhance care coordination among providers who provide medical care for patients outside the medical home; b. will urge CMS to assist physician practices seeking to qualify for <u>and sustain</u> medical home status with financial and other resources<u>; and</u> c. will advocate that Medicare incentive payments associated with the medical home model be paid for through system-wide savings – such as reductions in hospital admissions and readmissions (Part A), more effective use of pharmacologic therapies (Part D), and elimination of government subsidies for Medicare Advantage plans (Part C) – and not be subject to a budget neutrality offset in the Medicare physician payment schedule.~~; and~~ d. ~~will advocate that all health plans and CMS use a single standard to determine whether a physician practice qualifies to be a patient-centered medical home.~~ (Modify Current HOD Policy) 4. That our AMA advocate that all payers support and assist PCMH transformation and maintenance efforts at levels that provide a stable platform for optimized patient-centered care recognizing that payer support is crucial to the long-term sustainability of delivery reform. (New HOD Policy) 5. That our AMA encourage health agencies, health systems, and other stakeholders to support and assist patient-centered medical home transformation and maintenance efforts at levels that provide a stable platform for optimized patient-centered care. (New HOD Policy)	

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	Fiscal Note: Less than $500	
CMS Report 4: The Site-of-Service Differential (Resolution 817-I-17)	The Council on Medical Service recommends that the following be adopted in lieu of Resolution 817-I-17, and the remainder of the report be filed: 1. That our American Medical Association (AMA) reaffirm Policy H-240.993, which urges more aggressive implementation by the US Department of Health and Human Services of existing provisions in federal legislation calling for equity in payment between services provided by hospitals on an outpatient basis and similar services in physician offices. (Reaffirm HOD Policy) 2. That our AMA reaffirm Policy D-330.997, which encourages the Centers for Medicare & Medicaid Services (CMS) to define Medicare services consistently across settings and adopt payment methodology for hospital outpatient departments (HOPDs) and ambulatory surgical centers (ASCs) that will assist in leveling the playing field across all sites-of-service. (Reaffirm HOD Policy) 3. That our AMA reaffirm Policy H-400.957, which encourages CMS to expand the extent and amount of reimbursement for procedures performed in the physician office, to shift more procedures from the hospital to the office setting, which is more cost effective, and to seek to have practice expense relative value units reflect the true cost of performing office procedures. (Reaffirm HOD Policy) 4. That our AMA reaffirm Policy H-400.966, which directs the AMA to aggressively promote the compilation of accurate data on all components of physician practice costs, and the changes in such costs over time, as the basis for informed and effective advocacy concerning physician payment under Medicare. (Reaffirm HOD Policy) 5. That our AMA support Medicare payment policies for outpatient services that are site-neutral without lowering total Medicare payments. (New HOD Policy) 6. That our AMA support Medicare payments for the same service routinely and safely provided in multiple outpatient settings (eg, physician offices, HOPDs, and ASCs) that are based on sufficient and accurate data regarding the real costs of providing the service in each setting. (New HOD Policy) 7. That our AMA urge CMS to update the data used to calculate the practice expense component of the Medicare physician fee schedule by administering a physician practice survey (similar to the Physician Practice Information Survey administered in 2007-2008) every five years, and that this survey collect data to ensure that all physician practice costs are captured. (New HOD Policy)	Support

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	8. That our AMA encourage CMS to both: a) base disproportionate share hospital payments and uncompensated care payments to hospitals on actual uncompensated care data; and b) study the costs to independent physician practices of providing uncompensated care. (New HOD Policy) 9. That our AMA collect data and conduct research both: a) to document the role that physicians have played in reducing Medicare spending; and b) to facilitate adjustments to the portion of the Medicare budget allocated to physician services that more accurately reflects practice costs and changes in health care delivery. (Directive to Take Action) Fiscal Note: $100,000 to $200,000	
*CMS/CSAPH Joint Report 1: Aligning Clinical and Financial Incentives for High-Value Care	RECOMMENDATIONS The Council on Medical Service and the Council on Science and Public Health recommend that the following be adopted and that the remainder of the report be filed: 1. That our American Medical Association (AMA) reaffirm Policy H-155.960, which: supports "value-based decision-making" and reducing the burden of preventable disease as broad strategies for addressing rising health care cost; recognizes the important role of physician leadership, as well as collaboration among physicians, patients, insurers, employers, unions, and government in successful cost-containment and quality-improvement initiatives; and encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment, with consideration given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance. (Reaffirm HOD Policy) 2. That our AMA reaffirm Policy H-185.939, which supports flexibility in the design and implementation of Value-Based Insurance Design (VBID) programs and outlines guiding principles including that VBID explicitly consider the clinical benefit of a given service or treatment when determining cost-sharing or other benefit design elements, and that practicing physicians, including appropriate specialists, must be actively involved in the development of VBID programs. (Reaffirm HOD Policy) 3. That our AMA reaffirm Policy H-165.856, which supports a regulatory environment that enables rather than impedes private market innovation in product development and purchasing arrangements. (Reaffirm HOD Policy) 4. That our AMA support VBID plans designed in accordance with the tenets of "clinical nuance," recognizing that (1) medical services may differ in the amount of health produced,	Support

	and (2) the clinical benefit derived from a specific service depends on the person receiving it, as well as when, where, and by whom the service is provided. (New HOD Policy) 5. That our AMA support initiatives that align provider-facing financial incentives created through payment reform and patient-facing financial incentives created through benefit design reform, to ensure that patient, provider, and payer incentives all promote the same quality care. Such initiatives may include reducing patient cost-sharing for the items and services that are tied to provider quality metrics. (New HOD Policy) 6. That our AMA develop coding guidance tools to help providers appropriately bill for zero-dollar preventive interventions and promote common understanding among health care providers, payers, patients, and health care information technology vendors regarding what will be covered at given cost-sharing levels. (Directive to Take Action) 7. That our AMA develop physician educational tools that prepare physicians for conversations with their patients about the scope of preventive services provided without cost-sharing and instances where and when preventive services may result in financial obligations for the patient. (Directive to Take Action) 8. That our AMA continue to support requiring private health plans to provide coverage for evidence-based preventive services without imposing cost-sharing (such as co-payments, deductibles, or coinsurance) on patients. (New HOD Policy) 9. That our AMA continue to support implementing innovative VBID programs in Medicare Advantage plans. (New HOD Policy) 10. That our AMA support legislative and regulatory flexibility to accommodate VBID that (a) preserves health plan coverage without patient cost-sharing for evidence-based preventive services; and (b) allows innovations that expand access to affordable care, including changes needed to allow High Deductible Health Plans paired with Health Savings Accounts to provide pre-deductible coverage for preventive and chronic care management services. (New HOD Policy) 11. That our AMA encourage national medical specialty societies to identify services that they consider to be high-value and collaborate with payers to experiment with benefit plan designs that align patient financial incentives with utilization of high-value services. (New HOD Policy) Fiscal Note: $6,000	
Resolution 801:	RESOLVED, That our American Medical Association encourage the Centers for Medicare &	**Active Support**

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Encourage Final Evaluation Reports of Section 1115 Demonstrations at the End of the Demonstration Cycle Introduced by: Medical Student Section	Medicaid Services to establish written procedures that require final evaluation reports of Section 1115 Demonstrations at the end of each demonstration cycle, regardless of renewal status. (New HOD Policy) Fiscal Note: Minimal - less than $1,000.	
Resolution 802: Due Diligence for Physicians and Practices Joining an ACO with Risk Based Models (Up Side and Down Side Risk) Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	RESOLVED, That our American Medical Association advocate for the continuation of up side only risk Medicare Shared Savings ACO (MSSP ACO) program as an option from the Centers for Medicare and Medicaid Services, particularly for physician owned groups (New HOD Policy); and be it further RESOLVED, That our AMA develop educational resources and business analytics to help physicians complete due diligence in evaluating the performance of hospital integrated systems before considering consolidation. Specific attention should be given to the evaluation of transparency on past savings results, system finances, quality metrics, physician workforce stability and physician job satisfaction, and the cost of clinical documentation software (Directive to Take Action); and be it further RESOLVED, That our AMA evaluate the characteristics of successful physician owned MSSP ACOs and participation in alternative payment models (APMs) to create a framework of the resources and organizational tools needed to allow smaller practices to form virtual ACOs that would facilitate participation in MSSP ACOs and APMs. (Directive to Take Action) Fiscal Note: Estimated cost of $30,000 to implement resolution.	Oppose
Resolution 803: Insurance Coverage for Additional Screening Recommended in States with Laws Requiring Notification of	RESOLVED, That our American Medical Association support insurance coverage for supplemental screening recommended for patients with “dense breast” tissue following conversation between the patient and their physician (New HOD Policy); and be it further RESOLVED, That our AMA advocate for insurance coverage for and adequate access to supplemental screening recommended for patients with “dense breast” tissue following a conversation between the patient and their physician. (New HOD Policy) Fiscal Note: Minimal - less than $1,000.	Support

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"Dense Breasts" on Mammogram Introduced by: Resident and Fellow Section		
Resolution 804: Arbitrary Documentation Requirements for Outpatient Services Introduced by: Alaska	RESOLVED, That our American Medical Association agree that documentation for outpatient physician services should be completed in a timely manner (New HOD Policy); and be it further RESOLVED, That for circumstances in which more specific definitions of timeliness are required, AMA policy is that documentation for outpatient services should be completed, when possible, within 14 days of a provided service (New HOD Policy); and be it further RESOLVED, That our AMA work with government health plans and private insurers to help them better understand the unintended consequences of imposing documentation rules with unrealistically short timeframes, and that our AMA oppose the use of such rules or regulations in determining whether submitted claims are valid and payable. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	Support
Resolution 805: Prompt Pay Introduced by: Florida	RESOLVED, That American Medical Association policy H-190.959 be amended by addition and deletion to read as follows: Physician Reimbursement by Health Insurance and Managed Care Companies 1. Our AMA shall make it a top priority to seek regulatory and legislative relief to ensure that all health insurance and managed care companies pay for clean claims submitted electronically within ~~fourteen~~ three days. 2. When electronic claims are deemed to be lacking information to make the claim complete, the health insurance and managed care companies will be required to notify the health care provider within ~~five~~ one business days to allow prompt resubmission of a clean claim. 3. Our AMA shall advocate for heavy penalties to be imposed on health insurance and managed care companies, including their employees, that do not comply with laws and regulations establishing guidelines for claims payment. (Modify Current HOD Policy) Fiscal Note: Minimal - less than $1,000.	Monitor
*Resolution 806: Telemedicine	RESOLVED, That our American Medical Association advocate for removal of arbitrary limits on telemedicine visits by medical practitioners in nursing facilities and instead base them purely on	Support

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Models and Access to Care in Post-Acute and Long-Term Care Introduced by: AMDA – The Society for Post-Acute and Long-Term Care Medicine	medical necessity, and collaborate with AMDA – The Society for Post-Acute and Long-Term Care Medicine to effect a change in Medicare's policy regarding this matter under the provisions of Physician Fee Schedule (PFS) and Quality Payment Program (QPP) (New HOD Policy); and be it further RESOLVED, That our AMA work with AMDA-The Society for Post-Acute and Long-Term Care Medicine and other stakeholders to influence Congress to broaden the scope of telemedicine care models in post-acute and long-term care and authorize payment mechanisms for models that are evidence based, relevant to post-acute and long-term care and continue to engage primary care physicians and practitioners in the care of their patients. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	
*Resolution 807: Emergency Department Copayments for Medicaid Beneficiaries Introduced by: American College of Emergency Physicians	RESOLVED, That our American Medical Association oppose imposition of copays for Medicaid beneficiaries seeking care in the emergency department. (New HOD Policy) Fiscal Note: Minimal - less than $1,000.	**Active Support**
*Resolution 808: The Improper Use of Beers or Similar Criteria and Third-Party Payer Compliance Activities (H-185.940) Introduced by: Tennessee	RESOLVED, That our American Medical Association identify and establish a workgroup with insurers that are inappropriately applying Beers or similar criteria to quality rating programs and work with the insurers to resolve internal policies that financially penalize physicians (Directive to Take Action); and be it further RESOLVED, That our AMA study and report back to the House of Delegates the 2019 Interim Meeting, the potential inappropriate use of Beers Criteria by insurance companies looking at which companies are involved and the effect of the use of these criteria on physicians' practices (Directive to Take Action); and be it further RESOLVED, That our AMA provide a mechanism for members to report possible abuses of Beers Criteria by insurance companies. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	Support
*Resolution 809: Medicaid Clinical Trials Coverage	RESOLVED, That our American Medical Association actively lobby for and support federal legislation that guarantees coverage of routine patient care costs for Medicaid enrollees who participate in clinical trials. (Directive to Take Action)	Support

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Introduced by: American Society of Clinical Oncology	Fiscal Note: Modest - between $1,000 - $5,000.	
*Resolution 810: Medicare Advantage Step Therapy Introduced by: American Society of Clinical Oncology	RESOLVED, That our American Medical Association continue strong advocacy for the rejection of step therapy in Medicare Advantage plans and impede the implementation of the practice before it takes effect on January 1, 2019. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	Support
*Resolution 811: Infertility Benefits for Active-Duty Military Personnel Introduced by: American Society for Reproductive Medicine WITHDRAWN	RESOLVED, That our American Medical Association work with the Department of Defense, the American Society for Reproductive Medicine and other interested organizations to inform beneficiaries regarding the current availability of low-cost infertility care and gamete cryopreservation services at military treatment facilities for active-duty military personnel under Tricare (Directive to Take Action); and be it further RESOLVED, That our AMA work with the American Society for Reproductive Medicine (and the American College of Obstetricians and Gynecologists (ACOG) and the American Urological Association (AUA)) and other interested organizations to encourage Tricare to fully cover infertility diagnosis and treatment for active-duty military personnel and others covered by Tricare (Directive to Take Action); and be it further RESOLVED, That our AMA work with the American Society for Reproductive Medicine (and ACOG and AUA) and other interested organizations to encourage Tricare to fully cover gamete preservation prior to deployment for active-duty military personnel (Directive to Take Action); and be it further RESOLVED, That our AMA report back on this issue at the 2019 Interim Meeting. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	WITHDRAWN
*Resolution 812: ICD Code for Patients Harm From Payer Interference	RESOLVED, That our American Medical Association support the creation and implementation of an ICD code(s) to identify administrator or payer influence that affects treatment and leads to or contributes to, directly or indirectly, patient harm. (New HOD Policy) Fiscal Note: Not yet determined	Oppose

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Introduced by: Craig A. Backs, MD, Delegate		
*Resolution 813: Direct Primary Care Health Savings Account Clarification Introduced by: Indiana	RESOLVED, That our American Medical Association seek federal changes to the Internal Revenue Code allowing health savings accounts to be used with direct primary care. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	**Active Support**
*Resolution 814: Prior Authorization Relief in Medicare Advantage Plans Introduced by: Indiana	RESOLVED, That our American Medical Association support legislation that would apply the following legislative processes and parameters to prior authorization (PA) for Medicaid and Medicaid managed care plans and Medicare Advantage plans: • Listing services that require a PA on a website. • Notifying providers of any changes at least 45 days prior to change. • Standardizing a PA request form. • Not denying payment for PA that has been approved unless fraudulently obtained or ineligible at time of service. • Defining a consistent process for appeals and grievances, including to Medicaid and Medicaid managed care plans (New HOD Policy); and be it further RESOLVED, That our AMA apply these same legislative processes and parameters to prior authorization (PA) for Medicaid and Medicaid managed care plans and Medicare Advantage plans, to include: • Medications already working when a patient changes health plans cannot be changed by the plan without discussion and approval of the ordering physician. • Minimizing PA requirements as much as possible within each plan. • Making an easily accessible and reasonably responsive direct communication tool available to resolve disagreements between plan and ordering provider. (New HOD Policy) Fiscal Note: Modest - between $1,000 - $5,000.	Support
*Resolution 815: Uncompensated Physician Labor	RESOLVED, That our American Medical Association adopt policy that physicians should be compensated for reviewing and responding to new after-hour patient messages. (New HOD Policy)	Refer

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Introduced by: Indiana	Fiscal Note: Minimal - less than $1,000.	
*Resolution 816: Medicare Advantage Plan Inadequacies Introduced by: Indiana	RESOLVED, That our American Medical Association investigate the deficiencies of Medicare Advantage plans, with the goal of improving nursing home, rehab and physical therapy benefits. Full transparency about the cost and coverage of the plan, as well as communication about plan limitations, should be required (Directive to Take Action); and be it further RESOLVED, That our AMA issue an opinion on whether Medicare Advantage plans should be limited to healthier seniors with both a short problem list and short medication list, and whether there should be a cap on administrative costs for these plans. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	Support Resolve 1 Oppose Resolve 2
*Resolution 817: Increase Reimbursement for Psychiatric Services Introduced by: Indiana	RESOLVED, That our American Medical Association support increasing reimbursement for psychiatric services through direct funding adjustments or the CPT Editorial Panel process. (New HOD Policy) Fiscal Note: Minimal - less than $1,000.	Oppose
*Resolution 818: Drug Pricing Transparency Introduced by: Indiana	RESOLVED, That our American Medical Association advocate to the U.S. Surgeon General for federal legislation that investigates all drug pricing. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	Oppose
*Resolution 819: Medicare Reimbursement Formula for Oncologists Administering Drugs Introduced by: Michigan	RESOLVED, That our American Medical Association amend policy H-55.994 by addition to read as follows: Coverage of Chemotherapy in Physicians' Offices H-55.994 The AMA: (1) supports adequate reimbursement for outpatient oncology office visits that recognizes the complexity of the patient's care management; and (2) advocates that physicians who bill any third party payer for administering chemotherapy should ensure that the services billed for are described adequately and fully on the appropriate claim form and that the chemotherapy descriptors and code numbers provided by CPT are utilized (Modify Current HOD Policy); and be it further	Monitor

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	RESOLVED, That our AMA advocate for a change to the Medicare reimbursement formula such that the costs of chemotherapeutic agents are covered, plus an unrelated flat fee to cover the cost of the infusion or injection of said agents. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	
*Resolution 820: Ensuring Quality Health Care for Our Veterans Introduced by: Michigan	RESOLVED, That our American Medical Association amend policy H-510.986, "Ensuring Access to Care for our Veterans," by addition to read as follows: Ensuring Access to Safe and Quality Care for our Veterans H-510.986 1. Our AMA encourages all physicians to participate, when needed, in the health care of veterans. 2. Our AMA supports providing full health benefits to eligible United States Veterans to ensure that they can access the Medical care they need outside the Veterans Administration in a timely manner. 3. Our AMA will advocate strongly: a) that the President of the United States take immediate action to provide timely access to health care for eligible veterans utilizing the healthcare sector outside the Veterans Administration until the Veterans Administration can provide health care in a timely fashion; and b) that Congress act rapidly to enact a bipartisan long term solution for timely access to entitled care for eligible veterans. 4. Our AMA recommends that in order to expedite access, state and local medical societies create a registry of doctors offering to see our veterans and that the registry be made available to the veterans in their community and the local Veterans Administration. 5. Our AMA will strongly advocate that the Veterans Health Administration and Congress develop and implement necessary resources, protocols, and accountability to ensure the Veterans Health Administration recruits, hires and retains first-rate, competent, and ethical physicians and other health care professionals to deliver the safe, effective and high-quality care that our veterans have been promised and are owed. 6. Our AMA will engage the Veterans Health Administration in dialogue on accreditation practices by the Veterans Health Administration to assure they are similar to those of hospitals, state medical boards, and insurance companies. (Modify Current HOD Policy) Fiscal Note: Modest - between $1,000 - $5,000.	Monitor
**Resolution 821: Direct Primary Care and Concierge Medicine Based Practices Introduced by:	RESOLVED, That our American Medical Association actively lobby for revision to the U.S. tax code to allow funds from health savings accounts to be used for concierge medicine and direct primary care without incurring a tax penalty. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	Monitor

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Michigan		
**Resolution 822: Bone Density Reimbursement Introduced by: Georgia	RESOLVED, That our American Medical Association advocate for the correction of the underpayment by Medicare, Medicaid, and third party payers to medical practices for office-based DXA tests. (New HOD Policy) Fiscal Note: Not yet determined	Monitor
**Resolution 823: Medicare Cutes to Radiology Imaging Introduced by: Georgia	RESOLVED, That our American Medical Association advocate for elimination of the Medicare differential imaging payments for small practices versus facility payments (New HOD Policy); and be it further RESOLVED, That our AMA advocate for elimination of the Medicare computed radiography (CR) payment reductions. (New HOD Policy) Fiscal Note: Not yet determined	Monitor

*Included in the Handbook Addendum
** Included in the Sunday tote