June 29, 2024

To:
Benjamin W. Eidem, MD, FASE
Theodore Abraham, MD, FASE

Subject: 2024 Annual American Medical Association HOD meeting Summary Report

Dear Drs Eidem and Abraham:

This is a brief summary of the 2024 annual AMA HOD meeting that ran from June 7th-June 12th 2024 in Chicago. Approximately 85% of delegates attended the meeting. There was a lot of excitement and high energy overall.

This meeting is organized first into caucuses which are made up by organ system from subspecialty societies and the other half of delegates are from state associations. ASE currently has two delegates (Dr Rahko and I) which allows us considerable latitude in leveraging in the services of AMA on many topics that you are well aware of.

At the assembly, there is first the collection of resolutions that may be sent in by any delegate from either state associations or subspecialty societies for consideration. The reference committees' function much like congressional hearings, where each resolution is presented by its advocate to a committee and anybody who is attending the hearings can stand up and comment upon. Controversial topics take long periods discussion. These resolutions are then worked through by the reference committee and are recommended for adoption or not adoption or are rewritten, revised, or consolidated with multiple resolutions. The reference committees also hear reports from various societies of the AMA, usually on topics that were reports from previous meetings.

The cardiovascular medicine caucus gives us an opportunity to directly meet with delegates from ACC, other subspecialties societies such as SCAI, ASNC, HRS, SCCT, SCMR etc. This gives us a good cross section of how other organizations are viewing these issues. There is also a subspecialties service (SSS) caucus which encompasses all subspecialty societies that meets multiple times throughout the meetings, and they give you another cross-sectional flavor as to what other subspecialties societies are interested in and concerned about. Dr Rahko and I attended these meetings as delegates of the house supported by Katherine Stark who is the new Director of Advocacy from ASE.

Though there were a limited number of resolutions pertinent to cardiology community broadly and to ASE in particular, there were many interesting and important resolutions which were discussed. I will provide a summary of the meeting below:

Friday, 6/7/24:

Dr. Jesse Ehrenfeld MD, PHD, the outgoing 178th President outlined the reasons why physicians fight on behalf of their patients and their profession. He discussed the privilege and responsibility that comes with being a physician advocate in his final remarks to the assembled AMA House of Delegates. This was one of the best outgoing speeches that I have heard in the recent years. It was filled with passion, angst, the trials and tribulations that he faced in this divided political climate. He touched on Medicare physician pay cuts, Medicare reform regarding payment system, right the burden of prior authorization (CMS has released a final rule making important reforms to prior authorization to cut patient care delays and electronically streamline the process for physicians. Together, the changes will save physician practices an estimated $15 billion over 10 years, according to the U.S. Department of HHS), discussed physician burnout and also how to protect patients from inappropriate scope of practice expansions.

This was followed by Dr James Madara, the CEO of AMA announced that he will not seek to renew his contract when it expires next June and that his focus "now shifts to ensuring a smooth and effective transition to the next CEO." Dr. Madara took over as the AMA's CEO in 2011, succeeding Michael Maves, MD, who he credited for stabilizing the AMA's finances and operations. This stability allowed Dr. Madara to concentrate on developing a policy-driven strategic plan with focus and impact—one that has allowed the AMA to flourish in recent years.

This was followed by the nominations of various positions to serve the AMA.

Saturday, 6/8/24 and Sunday, 6/9/24:

Meeting of reference committees as follows:

- Reference Committee on Amendments to Constitution & Bylaws, which covers the **AMA constitution, bylaws and medical ethics matters**
- Reference Committee A which covers **Medical Service**
- Reference Committee B, which covers **Legislation**
- Reference Committee C, which covers **Medical education**
- Reference Committee D, which covers **Public Health**
- Reference Committee E, which covers **Science and Technology**
- Reference Committee F, which covers **Finance**.
- Reference Committee G, which covers **Medical practice**

Monday, 6/10/24 - Wed, 6/12/24:

Reference Committee F

BOT report #28 dealt with encouraging collaboration between physicians and industry in AI Development and digital health technologies. There was robust discussion on whether this should be referred or be accepted as a task force that would ultimately become a council.

Resolution 603 discussed the attack on health and human rights in Israel and Palestine.

 # Reference Committee on Amendments to Constitution and Bylaws:

Resolution 001 was adopted, and dealt with research regarding technology, measures, and effective use of personal and biological data to assess which supports professional workforce wellbeing and inform organizational interventions to mitigates burnout, and developed ethical guidelines on the collection, use, and protection of personal and biological data obtained to improve for the professional workforce wellbeing.

The following 2 resolutions were recommended for referral at this time:
Resolution 16 advocates for the development of adequate policies and / or legislation to address the healthcare needs of migrants and asylum seekers in cooperation with relevant legislators and stakeholders based on the following guiding principles, adapted from the High-level meeting of the Global Consultation on Migrant Health, i.e. the "Colombo Statement". AMA recognizes that migration status is a social determinant of health, affirms the importance of multi-sectoral coordination and inter-country engagement and partnership in enhancing the means of addressing health aspects of migration and recognizes that the enhancement of migrants' health status relies on an equitable and non-discriminatory access to and coverage of health care and cross-border continuity of care at an affordable cost avoiding severe financial consequences for migrants, as well as for their families.

CEJA Report 03 dealt with establishing ethical principles for physicians involved in private equity owned practices

 # Reference Committee G:

CMS Report 6 dealt with economics of prescription medication prior authorization. This includes (1) a detailed explanation of the denial reasoning, (2) a copy of or publicly accessible link to any plan policy or coverage rules cited or used as part of the denial, and (3) what rationale or additional documentation would need to be provided to approve the original prescription and alternative options to the denied medication.

There is a push to implement a Real Time Prescription Benefit (RTPB) Real-Time Benefit Tool (RTBT) standard that meets the needs of all physicians and other prescribers, utilizing any electronic health record (EHR), and prescribing on behalf of any insured patient and advocate that all payers (i.e., public and private prescription drug plans) be required to implement and keep up to date an RTPB RTBT standard tool that integrates with all EHR vendors. Also, regulation and monitoring of third-party Pharmacy Benefit Managers (PBMs) is to be done in an effort to control prescription drug pricing, and to continue advocacy efforts to ensure that physicians have access to real-time formulary data when prescribing.

 # Reference Committee E:

Resolution 504 asked AMA to encourage the FDA to continually collect data and critically evaluate biosimilar utilization including the appropriateness of the term "interchangeable" in regulatory activities. AMA urges that State Pharmacy Practice Acts and substitution practices for biosimilars in the outpatient arena: (1) preserve physician autonomy to designate which biologic or biosimilar product is dispensed to their patients; (2) allow substitution when physicians expressly authorize substitution of an interchangeable a biologic or biosimilar product; (3) limit the authority of pharmacists to automatically substitute only those biosimilar products that are deemed interchangeable by the FDA. in the absence express physician authorization to the contrary, allow substitution of the biologic or biosimilar product when (a) the biologic product is highly similar to the reference product, notwithstanding minor differences in clinically inactive components; and (b) there are no data indicating clinically meaningful differences between the biological product and the reference product in terms of the safety, purity, and potency of the product.

Resolution 506 generated a lot of discussion especially as this appears to be significant amount of image manipulation in research publications which is rampant in the age of AI. Currently, there are no reliable software solutions that are trained to identify the image manipulation. This resolution is recommended not for adoption and referred at this time. <u>This will be of interest to ASE as we have publications such as JASE, CASE and other educational products.</u>

Resolution 503 dealt with unregulated hemp-derived intoxicating cannabinoids and derived psychoactive cannabis products (DPCPs)

Resolution 508 specifically asks AMA to support regulations to decrease overdoses in children due to ingestion of edible cannabis.

Resolution 512 generated dialogue to also have opioid overdose reversal agents where AED's are located. This is was recommended for reaffirmation as there was mixed testimony.

Resolution 509 deals with under recognition of sarcopenia It asks that AMA collaborate with appropriate entities to develop and implement educational awareness targeting healthcare professionals, caregivers, and the elderly population to increase knowledge about sarcopenia, its risk factors and consequences, in order to facilitate prevention, early recognition and evidence-based management as a routine part of clinical practice with elderly patients and that AMA support that following mitigatory steps: (1) support nutritional interventions aimed at optimizing protein intake, essential amino acids, and micronutrients; (2) promote regular physical activity, including resistance training, aerobic exercise, and balance exercises, tailored to individual capabilities and preferences and that AMA support allocation of resources for research initiatives aimed at advancing our understanding of sarcopenia, its pathophysiology, risk factors, and treatment modalities and that AMA advocate for policy changes to support reimbursement for sarcopenia screening, diagnosis, and interventions, collaborate with all stakeholders to integrate sarcopenia prevention and management into public health agendas and aging-related initiatives.

Resolution 517 saw unanimous testimony which described the frustrations of trying to keep up with the rapidly evolving landscape of tobacco and nicotine products, many of which are currently being

designed to circumvent the regulations specifically in place to protect the public well-being, and asked AMA to oppose the development, production, market and sales of nicotine analogue consumer products and to urge FDA Center for Drug Effectiveness and Research to swiftly exert its authority to regulate all nicotine analogue products as drugs.

 # Reference Committee A:

Resolution 116 discussed the need for increase insurance coverage for follow-Up testing after abnormal screening mammography

Resolution 103 resulted in robust testimony is strong support of the resolution. It asked AMA to urge the United States Congress and Center for Medicare and Medicaid Services to take steps to end the upcoding for Medicare Advantage plans that results in high subsidies which are unfair to traditional Medicare and burdensome to the public treasury and many beneficiaries, improve the attractiveness of traditional Medicare so that the option remains robust and available giving beneficiaries greater traditional choices for this option and to seek better care for themselves.

 # Reference Committee C:

BOT report is in regards to the Morill act and its impact on the diversity of the physician workforce. AMA has been asked to support American Indian ((AI/AN) health career opportunities recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations to include training a workforce from and for these tribal nations. AMA acknowledges the significance of the Morrill Act of 1862, the resulting land-grant university system, and the federal trust responsibility related to tribal nations. In addition, AMA is charged with representation of AI/AN physicians in medicine and promotion of effective practices in recruitment, matriculation, retention, and graduation of medical students.

Resolution 302 was recommended for reaffirmation, and deals with MOC. AMA is charged with adopting a policy that states that maintenance of certification requirements should not be duplicative of continuing medical education requirements and not be used to determine or dictate hospital privileges, insurance network credentialing, or hiring practices, recognize the importance of fostering competition in the market for board certification, allowing physicians to have the autonomy to choose the most suitable pathway for their individual learning and professional development needs, undertake a comprehensive review of the available evidence concerning the impact of maintenance of certification on the quality and safety of patient care and report the findings of this investigation to its members and stakeholders, including policymakers and legislators, to inform future healthcare policy with a report back to the HOD by Annual 2025.
Resolution 316 is reaffirmed, and deals with reassessment of continuing board certification process. American Medical Association was asked to undertake a thorough review and analysis of the available literature, data, and evidence to re-examine and update the accepted standards for continuing board certification including policy, Specialty Board Certification Standards, so the standards reflect the best manner to assess physicians' knowledge and skills necessary to practice medicine.

 # Reference Committee D:

CSAPH report 3 supports removal of BMI as a standard measure in medicine and recognizing a culturally-diverse and varied presentations of eating disorders. It was felt that the issues with using 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 are based primarily on data collected from previous generations of non-Hispanic White 28 populations and does not consider a person's gender or ethnicity. There is 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: visceral fat, body adiposity index, body composition, relative fat mass, waist circumference and genetic/metabolic factors. It is felt that BMI is significantly correlated with the amount of fat mass in the general population but loses predictability when applied on the individual level that relative body shape and composition heterogeneity across race/ethnic groups, sexes, and age-span is essential to consider when applying BMI as a measure of adiposity. It was also felt that the use of BMI should not be used as a sole criterion to deny appropriate insurance reimbursement. BMI should be evaluated within the context of comorbidities, baseline mortality risk, and environmental factors such as chronic stressors, poor nutrition, and low physical activity may be used for risk stratification. BMI is a widely used tool for population level surveillance of obesity trends due to its ease of use and low risk for application inconstancies, but BMI does not fully capture the complexity of the obesity epidemic. In addition, BMI, in combination with other anthropometric measures and environmental factors, may be useful as an initial screener to identify individuals for further investigation of metabolic health risks.

Resolution 430 deals with supporting the inclusion of information about lung cancer screening within cigarette packages. AMA was also directed to work with appropriate public health organizations and governmental agencies to monitor the impact of "non-combustible tobacco" nicotine delivery devices on cancer epidemiology and promote appropriate cancer screening.

 # Reference Committee B:

Resolution 207 supports economic incentives to increase physician use of less expensive biosimilars instead of their reference biologics and to encourage the Federal Trade Commission (FTC) and Department of Justice (DOJ) Antitrust Division to closely scrutinize long-term exclusive contracts signed between biologics originators and PBMs to ensure they do not impede biosimilar development and uptake.

Resolution 235 directs AMA to advocate with Congress, through the appropriate oversight committees, and with the CMS to require that Medicare Advantage (MA) plans cover physician administered drugs and biologicals in such a way that the patient out of pocket cost is the same or less than the amount that a patient with traditional Medicare plus a Medigap plan would pay.

In summary, there was a huge volume of resolutions presented but the vast majority of them did not have direct impact on ASE and the vast majority did not have direct impact on cardiovascular disease or medical imaging. However, resolutions 506 deals with medical imaging manipulation and will be

important to us as we publish JASE and CASE journals. Resolutions 316 and 302 deal with both board certification and MOC standardization. We will be following these resolutions intently at the interim AMA 2025 meeting, and will provide updates accordingly.

Again, it was our pleasure to serve ASE by attending the annual AMA 2024 meeting. Not only do we have the ability to interact on issues directly but also it is also vital to maintain our delegate status so that the society can maintain all the advantages particularly at the RUC committee where we can have direct access and not have to go through associations such as ACC. We also want to particularly acknowledge and welcome Katherine Stark to the advocacy committee while maintaining our presence at AMA. Katherine has already made multiple important contacts with AMA personnel and other subspecialty societies that are invaluable to ASE. She is very knowledgeable about policy, and is well respected.

Please feel free to contact us if you have questions or need additional information. Katherine Stark has all of the details if you so desire to explore any of these substantial reports or resolutions.

Sincerely,

Kamu Maganti, MD, FASE
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cc:
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