HOD ACTION: Council on Medical Education Report 14 adopted as amended and the remainder of the report filed.

REPORT 14 OF THE REPORT OF THE COUNCIL ON MEDICAL EDUCATION (A-10)
Opposition to Increased CME Provider Fees
(Reference Committee C)

EXECUTIVE SUMMARY

Resolution 302 (A-09) asked for the American Medical Association (AMA) to study and report back on the system of intrastate accreditation, including the Accreditation Council for Continuing Medical Education (ACCME) fee structure for state accreditors and their providers, the concept of equivalency, the new criteria for compliance, and the impact these changes will have on state accreditors and their providers.

CME Report 14 explains AMA's function as the owner of the *AMA PRA Category 1 Credit* ™ system and traces AMA's long involvement with the accreditation of intrastate/local CME providers. This report summarizes the results of two surveys conducted in July 2009 to gain an understanding of how the intrastate CME system is being affected by new ACCME rules and fees. The studies show that the continued viability of the intrastate CME system may be threatened as the number of intrastate CME providers is declining, and there is no evidence to suggest that this trend will reverse itself. The combined effect of the ACCME updated criteria, markers of equivalency, and increased fees for intrastate providers is that a significant number of local CME providers have left the system or are contemplating doing so in the future.

The report also describes the ACCME's fee structure for state accreditors and their providers but is unable to answer questions as to the rationality of the costs that the ACCME assigns to the intrastate system. In addition the report describes the evolution of the ACCME structure and notes how the voice of the AMA and the other ACCME member organizations has been diminished over time. The divergence of the ACCME accreditation system from the AMA PRA credit system is also described. The report goes on to explain actions taken by the AMA to address these concerns and how the ACCME has positively responded to our requests.

The report calls for the AMA to take action to commend the ACCME for their recent actions and to continue to work with the ACCME to forestall any further decline in the intrastate CME system that could result in decreased access to quality, cost-effective continuing medical education at the local level.

HOD ACTION: Council on Medical Education Report 14 adopted as amended and the remainder of the report filed.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 14-A-10

Subject: Opposition to Increased CME Provider Fees

Presented by: Susan Rudd Bailey, MD, Chair

Referred to: Reference Committee C
(Floyd A. Buras, Jr., MD, Chair)

Resolution 302 (A-09), "Opposition to Increase CME Provider Fees," which was introduced by the Illinois Delegation and adopted by the House of Delegates (HOD), asked that our American Medical Association (AMA):

> Study and report back at the 2009 Interim Meeting on the system of intrastate accreditation, including the Accreditation Council for Continuing Medical Education (ACCME) fee structure for state accreditors and their providers, the concept of equivalency, the new criteria for compliance, and the impact these changes will have on state accreditors and their providers. (D-300.982, AMA Policy Database)

The Council on Medical Education submitted an informational report for the 2009 Interim Meeting noting that additional time was needed to analyze the data that had been collected in order to prepare a comprehensive report for the 2010 Annual Meeting.

BACKGROUND

AMA Physician's Recognition Award (PRA) and credit system

The AMA established the AMA Physician's Recognition Award (PRA) in 1968 to recognize physicians who demonstrate their commitment to staying current with advances in medicine. The credit system derived to support this award has evolved as the "common currency" for physicians in the United States (US) to meet continuing medical education (CME) requirements for multiple purposes including licensure, board certification, and hospital credentialing.

Accreditation of CME Providers wishing to Award AMA PRA Category 1 Credit™

A formal system of approval of CME providers in the US operated by the AMA was in place as far back as 1967. In 1970, the AMA HOD adopted a set of "Essentials for the Accreditation of Institutions and Organizations" that then became the basis for accreditation of CME providers. The AMA committee charged with this function was sensitive to the need to make quality CME accessible in rural and isolated locales and worked with the state medical societies to develop equivalent standards of quality for smaller organizations, e.g., community hospitals and state specialty societies, so that these organizations also might become accredited.

As the demand for CME credit increased, the AMA joined with other organizations to form the Liaison Committee on Continuing Medical Education in the late 1970s but the experiment failed. In 1981 the AMA joined with six other national organizations to be parent/member organizations of the ACCME. At the time of its founding, the ACCME Essentials and Guidelines, adapted in part from the AMA Essentials, mirrored the AMA PRA credit requirements. Currently, the ACCME directly accredits 713 national CME providers and also recognizes the 45 state/territorial medical societies (SMS) that accredit 1,523 intrastate/local CME providers. [1]

AMA Relationship to the ACCME

Since the ACCME's beginning, the AMA has allowed CME providers accredited directly by the ACCME, or by SMS recognized by the ACCME through its Committee for Review and Recognition (CRR), the privilege to grant *AMA PRA Category 1 Credits* ™ for the CME activities that they produce in accordance with the AMA PRA credit system requirements. And while the AMA has always maintained the right to withdraw a CME provider's privilege to award AMA PRA credit, the AMA has relied on the ACCME and the SMS to assure that activities produced by its accredited/recognized CME providers are in compliance with the AMA PRA credit requirements.

The reason organizations seek accreditation through the ACCME or the SMS is to be able to designate activities for *AMA PRA Category 1 Credits* ™ and award these credits to physicians that participate in the CME provider's activities. CME providers are not required to register with the AMA or pay a fee for this entitlement. The AMA derives no income from either the ACCME, the SMS, or from individual physicians for the use of its credit system. The AMA has not afforded any other accreditation program in the US this privilege.

ACCME Governance

The additional six founding and still current member organizations of the ACCME are: the American Board of Medical Specialties; the American Hospital Association; the Association for Hospital Medical Education; the Association of American Medical Colleges; the Council of Medical Specialty Societies; and the Federation of State Medical Boards. The original ACCME bylaws[2] provided member organizations with single member veto power and the right to directly appoint members to the Council and its committees. Member organizations maintained close working relationships with their appointees through staff liaisons that attended Council meetings, participated in committee discussions, and communicated member organizations' positions and information to them as well as to the rest of the ACCME Board of Directors. As a result, the AMA and the other member organizations provided input to ACCME policy-making discussions affecting the accreditation of CME providers that award *AMA PRA Category 1 Credit*™. However, actions taken by the ACCME over the past few years have increasingly limited member organization staff liaisons' participation in ACCME Board of Directors (BOD) and Board Committee meetings, so the direct communication between the member organizations and the BOD has been dramatically reduced.

In 2003, with the agreement of the seven parent organizations, the ACCME was separately incorporated and new bylaws were established to reflect those changes necessary for incorporation. With the revision of the ACCME bylaws[3] that occurred in 2005, approved by all the member organizations, the single organization veto was removed and the rights of member organizations were defined as follows: 1) to nominate directors; 2) to designate representatives; 3) to allow nominated directors to serve as officers; 4) to nominate executive committee members; 5) to

receive notice of ACCME actions and to be able to call out actions of the ACCME only if these are outside the purpose and function of the ACCME; 6) to receive annual financial statements; 7) to pay expenses of nominated directors; and 7) to participate in the amendment of bylaws.

Other US Credit/Accreditation Systems

There are two other well established physician CME credit systems in the US. The American Academy of Family Physicians (AAFP) credit system, the first credit system established in the US in 1948, allows CME providers to apply on an activity-by-activity basis to award "Prescribed" or "Elective" credits. In addition, the American Osteopathic Association (AOA) has a system of institutional accreditation that allows the organizations that it accredits to award Osteopathic CME credits to physicians. These systems are dedicated to serving the specific needs of their constituent physicians and are recognized by many of the state licensing boards and credentialing agencies that also recognize AMA PRA credits. These programs are administered directly by the AAFP and the AOA and, while both use standards for commercial support that are similar and sometimes the same as the ACCME's standards, neither defers to the ACCME to accredit organizations or approve activities. There is, however, a great deal of communication and cooperation among the AMA, AOA, and AAFP credit systems and their rules are similar in many ways.

DIVERGENCE OF ACCME ACCREDITATION FROM AMA PRA CREDIT REQUIREMENTS

The Council on Medical Education has been charged by the House of Delegates to establish requirements and approve learning formats for activities to be certified for *AMA PRA Category 1 Credit*™. As noted earlier, when the ACCME was established, the accreditation requirements and the requirements for certifying an activity for *AMA PRA Category 1 Credit*™ were essentially the same. The ACCME accreditation system also monitored for compliance with the AMA requirements. However, over the years there has been a divergence between the accreditation requirements and the AMA's requirements for certifying CME activities, and the ACCME has not actively monitored for compliance with the PRA requirements. The AMA's core requirements, which are based on sound, well-recognized adult education principles, have essentially stayed the same for the past thirty years with the Council on Medical Education approving additional learning formats to reflect physician's needs, the changing practice environment, and new technologies, e.g., performance improvement CME and Internet Point of Care. As changes were contemplated in 2005 for the most recent PRA informational booklet, where the AMA PRA rules are described, the AMA asked and received input from the ACCME as the AMA attempted to ensure that the systems were complementary and that accredited providers would be able to plan activities that would meet AMA requirements while meeting the accreditation requirements.

The new ACCME criteria and other previously introduced interpretations that are no longer consistent with previously established definitions have created confusion in the CME community.

For example, the current definition of CME shared by both the AMA and ACCME states:

> CME consists of educational activities which serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public or the profession. The content of CME is the body of knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine, and the provision of health care to the public.

Information that was presented at the 2009 Alliance for CME Annual Conference, and was expanded in a posting on the ACCME Web site after the meeting, stated that certified educational

activities that were designed only to change knowledge would be found "noncompliant." It further stated "Addressing a learner's need for knowledge is certainly an important part of the learning journey and the educational experience; however, the CME program, through its activities must be designed to go further."

The Council is concerned that this interpretation of the definition of CME will exclude important knowledge-based, academic, research-related, and/or non-clinical subject matter that are as important to a physician's continuing education as those topics that relate to changing performance. Consequently, a physician's need to integrate fundamental knowledge through certified CME will be unmet.

There needs to be consistency between the AMA and the ACCME definitions, interpretations, and requirements. Physicians depend on this dual system of accreditation/certification of credit to ensure that they are participating in quality continuing medical education that will improve patient care. Divergence between AMA and ACCME definitions contributes to the complexity in the accreditation and credit certification processes.

STATUS OF THE STATE ACCREDITATION SYSTEM RECOGNIZED BY ACCME

The majority of the organizations accredited by the 45 SMS recognized by the ACCME are hospitals and state specialty societies that provide CME activities for physicians at the local level. Originally, 54 states/territories served as intrastate accreditors. From the time that the CRR was established in 1985 until 1999, only two SMS were withdrawn as recognized state accreditors, but since 1999 seven additional states have opted out or had recognition withdrawn by the ACCME. Information provided by the ACCME documents efforts to communicate with the CME providers affected by these withdrawals and to offer alternatives for remaining accredited including the potential for accreditation by a SMS in a contiguous state. Information provided by the ACCME and gathered in 2009 from an AMA inquiry of Chief Staff Officers from SMS that no longer provide accreditation services suggests that, with the increased complexity of requirements and resources required to maintain ACCME recognition, several of these states concluded it was no longer financially feasible to continue to provide this service.

Of great concern is that the number of intrastate providers accredited through the SMS has significantly declined, and there is no indication that this trend will reverse itself in the near future. The activities produced by these intrastate CME providers are critical to a physician's professional development because they address local educational and practice needs that are specific to the patient populations where the physician actually practices. Since 2003, intrastate providers have declined by 261 (1,784 providers in 2003 and 1,523 in January 2010), or 14.6% based on figures available at the ACCME web site.[1] The ACCME's most recent annual report for 2008[4] documents a reduction of 63 (4%) intrastate accredited CME providers just between 2007 and 2008 and there has been a further decline since then. In addition, between 2007 and 2008, aspects of programming for intrastate providers declined in terms of the percent of activities presented (1%), hours of programming (6.5%), and physician participants (5%).

It is of significant concern that these reductions are occurring at a time when hospital and other local CME providers, which have access to performance data, could be offering assistance to the physicians they serve by implementing performance improvement continuing medical education (PI CME) that is certified for *AMA PRA Category 1 Credits*™, contributes to improving patient care and may be recognized for multiple data reporting purposes. Further decline of the SMS accreditation system may seriously impede the delivery of cost-effective, quality, accessible certified CME that deals first and foremost with local health care issues.

CHANGES IN THE ACCME SYSTEM

ACCME Updated Criteria for Accreditation

Prior to 2006, the ACCME had been operating under "System 98," an accreditation model introduced in 1998 that consisted of three "essential areas," or requirements for accredited CME providers, along with nine "elements," or criteria for compliance with these accreditation requirements. This model was aligned with the AMA's definition of CME as well as AMA PRA credit system guidelines.

In September 2006, the ACCME announced revisions to its accreditation system. The new 2006 accreditation criteria[5] represent some significant shifts in the ACCME's expectations of CME providers, as well as a departure from their alignment with AMA PRA guidelines. For example, one shift in the new criteria requires providers to demonstrate how their CME programs effect change in physician competence, performance, or patient outcomes.

ACCME Markers of Equivalency[6]

From 1985 to 2009, the recognition of state medical societies as accreditors of intrastate CME providers was guided by a Protocol for the Recognition of State Medical Societies to Accredit Intrastate Continuing Medical Education Sponsors ("Protocol"). This Protocol was drafted with input from the SMS as well as the ACCME's seven parent organizations. The Protocol, which operated under the assumption that SMS' authority to accredit intrastate providers was inherent, and not delegated by the ACCME, was approved by the AMA House of Delegates at its 1985 Annual Meeting.

The Protocol required SMS accreditors to adopt a set of Essential Areas, Elements, Criteria, and Policies "at least as stringent as" the ACCME's. It should be noted that the "as stringent as" language allowed for SMS to adopt criteria that were more rigorous than the ACCME's; and in fact, some SMS accreditors did so. The Protocol thus set the conditions whereby an SMS would be recognized as part of a national network of CME accreditation. While it was necessary to have an organization (ACCME) ensure a minimum standard, the underpinning was that the SMS accreditors and the ACCME were equal partners in the accreditation system. The Protocol also established the CRR, a standing committee of ACCME that was given direct authority over review and recognition decisions, which were then reported to the ACCME for documentation.

The relationship between the ACCME and the CRR was changed in 2002 so that the CRR would no longer make the final recognition decisions but rather would recommend actions for final approval by the ACCME Board of Directors.

In 2007, the ACCME convened seven representatives from the SMS system to form an Advisory Committee on Equivalency (ACE), charged with helping the ACCME identify and define the critical features that would mark equivalency among accreditors. The ACE reviewed data provided by the ACCME that cited specific instances of SMS variance with the ACCME's accreditation process, including the manner in which files were selected for review, the ways in which activities

were reviewed, tactics used when providers do not demonstrate improvement on progress reports, and the status and terms of accreditation. A series of meetings was held that resulted in the ACE endorsing the ACCME staff's proposed framework for equivalency in August 2007.

The markers of equivalency outline criteria for demonstrating (1) equivalency of rules; (2) equivalency of process; (3) equivalency of interpretation; (4) equivalency of outcomes; and (5) equivalency of evolution/process improvement. One area of concern lies with the criteria for "equivalency of outcomes," which mandates that accreditation outcomes (e.g., accreditation terms, accreditation status, and progress reports) must be consistent with the 4-year/6-year accreditation terms established by the ACCME. This is problematic because many state-accredited CME providers do not have full-time staff assigned to CME and there is also often significant staff turnover. Many SMS accreditors prefer shorter accreditation terms to more closely monitor these providers who, due to the staffing realities, do not have the kind of continuity that larger national providers enjoy.

As noted, prior to equivalency, the Protocol required SMS accreditors to adopt a set of Essential Areas, Elements, Criteria and Policies "at least as stringent as" the ACCME's. The new recognition requirements require as a marker of equivalency state accreditors to use the "ACCME's Accreditation Requirements that are applicable at the time…as the basis for each accreditation decision." There is no allowance for the SMS accreditors to be involved in determining any changes in that process; the ACCME can make revisions or new requirements that will apply to the SMS without input from the SMS. Unlike the Protocol, which was reviewed and approved by the ACCME's constituents and parents, including the AMA House of Delegates, neither the markers for equivalency nor the 2006 ACCME revised accreditation criteria were approved by member organizations. Further, it is unclear how markers for equivalency will improve the process, since the previous Protocol already required SMS to have criteria "at least as stringent as" the ACCME's criteria.

ACCME Fees for the State Accreditation System

The ACCME's Committee on Review and Recognition (CRR) which oversees the recognition of the SMS has a process, similar to the accreditation process, in which each SMS undertakes a self-study, is surveyed by ACCME volunteers, reviewed by the CRR, and a recommendation on recognition is made to the ACCME Board of Directors (BOD). The ACCME traditionally has had no direct relationship with the intrastate CME providers; the SMS handle all accreditation functions and serve as the resource for these providers.

Until 2004, each SMS paid a $3,850 fee for the rerecognition process, the same fee as applied to reaccreditation of ACCME CME providers. In addition, the recognized SMS paid a $40 annual fee for each CME provider that was accredited by the state. In 2004, the ACCME increased the fees for these state accredited providers to $80 but then eliminated the rerecognition fee for the SMS. The total fees that each SMS paid varied from $240 to $27,200, based on the number of accredited CME providers. Most SMS have incorporated this cost into the fees that are charged to their CME providers for accreditation services.

In 2008, the ACCME communicated to the SMS that only 6% of its income was derived through the SMS system and the other 94% came from the accreditation system. ACCME calculated that the SMS system received 40% of the services of the ACCME. The ACCME indicated that the recognition process annually cost the ACCME $642,266 and the SMS education expenses were $879,439. According to the ACCME, the expenses incurred for support of the SMS system averaged $33,081 per state accreditor annually.

The ACCME projected that the expense for support of the SMS system would increase from $3,805,534 in 2007 to $5,298,600 in 2011, an increase of 39% in 4 years. To fund this increase in expenses, the ACCME announced in 2008 that it would raise the annual fee for each intrastate provider from $80 to $550, an increase of 588%.

The SMS charge intrastate providers a fee to compensate for the expense of the accreditation services provided. These fees currently range from $100 - $22,000 for a four-year accreditation term, with the average being approximately $6,700. In most states, the increase in ACCME fees will be passed on to the intrastate providers, thus increasing the cost of a four-year accreditation by about $1,880.

The process of provider accreditation and state recognition involves similar resources from the ACCME, but the rationale for the 266% difference between the ACCME's projected future cost of accreditation in 2011 ($20,425/4 years) and recognition ($74,800/4 years) is not evident.

The cost of accrediting the SMS CME providers, which in many cases includes education and consultation, is borne by the SMS themselves. SMS costs are often covered in part or completely by fees paid by their accredited providers, fees that can be almost as high as the ACCME accreditation fees. As noted previously, in the past the ACCME charged SMS a recognition fee similar to the accreditation fees charged to ACCME providers. This made sense since the process of recognition and the process of accreditation are similar in several ways. When viewed in that manner, with 45 recognized SMS and 713 ACCME accredited providers, the percentage of the ACCME costs that should be allocated to SMS would be 6 percent.

On October 30, 2008, a memo was sent from the ACCME to the recognized SMS regarding "ACCME Fees from SMS-Accredited Providers." However, the memo does not provide enough information to ascertain what expenses are being allocated to the state accreditation system in order to reach the conclusion that it receives services totaling 40% of the ACCME budget. And although the state accreditation system represents 68% of all the accredited providers compared to the ACCME accredited providers, it only produces 33% of all the activities (49,399 vs. 100,898), has only 19% of all the physician participants (2.55 vs. 10.67 million), receives only 3% of all the commercial support ($30.6 million vs. $1.036 billion), and 6% of the total income ($155.7 million vs. $2.365 billion).

DATA GATHERED REGARDING THE IMPACT OF ACCME CHANGES

Survey of Accredited Intrastate CME Providers

In response to Resolution 302 (A-09), in July of 2009, the AMA conducted a survey to better understand intrastate accredited CME providers' views on possible fee increases in the future and whether proposed changes to the ACCME accreditation criteria and rules would affect CME providers' willingness or ability to continue being accredited. Of the 1,323 individuals designated as contacts from the intrastate providers who received the survey, 549 responded for a response rate of 41%. There was feedback from all 46 states that had ACCME recognized accreditation programs at that time.

A few comments are in order about the survey itself and the findings that follow. First, a response rate of 41% for the CME providers is quite respectable given the complexity of the topic and the questions that were posed as well as the length of the survey. Second, there were a few CME provider attributes that were examined as part of these analyses, such as, size of the CME program; years in operation; and type of CME organization. None of these variables had any impact on the response patterns. Thus, these CME respondents can be viewed as a homogeneous group when it

comes to examining their responses to specific survey items. The third and final observation has to do with the survey items themselves. While each issue, such as staff resources, increase in fees, declining or increasing enrollments in courses, scope of course offering, etc., can be view uniquely, it is clear that these items are intertwined and as such have a compounding impact on each other. It is not that any given requirement is perceived as either "easy or difficult" but rather it is the collective weight of these requirements that provides a context in which this information should be view and considered. It is the total package of requirements/obligations that has synergistic consequences beyond any one requirement.

The majority of responses were received from hospital and health care systems (75%) and state specialty societies (9%). The providers that responded to the survey report that they serve audiences of physicians ranging from 12-50,000, with an average of about 1,000. These providers produced on average 45 activities for 348 hours of instruction in 2008.

The overwhelming majority (86%) of respondents indicated that it was "very important" to their organization to be able to provide *AMA PRA Category 1 Credit* ™ to the physicians they serve. Another 14% indicated that this was somewhat important. Only 1 CME provider (less than 1%) answered that providing AMA PRA credit was not important.

When asked about the overall impact of the new ACCME criteria, almost 60% of respondents indicated that the criteria would make it more difficult to provide quality CME activities. Only 17% indicated that the new criteria would help their institution provide quality CME. Of the 15% that answered "other" to this question several comments were received indicating that the impact would be a decrease in the number of activities the provider would be able to produce.

Providers were asked to indicate the degree of ease or difficulty their organization might have in documenting compliance with each of the 22 ACCME criteria. While the majority of providers rated six criteria as being very easy or somewhat easy to document, 15 criteria were rated as being somewhat difficult to document, and one criterion was evaluated by the majority as being very difficult to document.

Providers were asked to indicate which factors might cause their organization to consider not being accredited in the future. Responses were as follows:

	Very likely	**Somewhat likely**	**Not very likely**	**Total**
Too much time involved	177 (40.8%)	171 (39.4%)	86 (19.8%)	434 (100%)
Lack of staff	156 (35.9%)	171 (39.4%)	107 (24.7%)	434 (100%)
Lack of physician support/involvement	135 (31.1%)	179 (41.2%)	120 (27.6%)	434 (100%)
Accreditation fee increase	78 (17.9%)	179 (41.1%)	179 (41.1%)	436 (100%)
Demonstrating compliance with 2006 ACCME accreditation criteria	63 (14.4%)	179 (41.0%)	195 (44.6%)	437 (100%)
Competition from other types of CME providers	58 (13.6%)	115 (26.9%)	255 (59.6%)	428 (100%)
Lack of commercial support	72 (16.7%)	101 (23.4%)	259 (60.0%)	432 (100%)

Another question on the survey asked providers to suggest "what else" the AMA should take into consideration in preparing this report for the HOD. Of the 269 individuals that answered this question, 128 indicated that the financial and staff resources necessary for the entire accreditation process are a concern. Another 73 indicate that documenting compliance with the new criteria is a challenge. A summary of results from this question may be found in Appendix A.

Perhaps the most significant finding from this survey is that 34% of these intrastate providers report that their organizations are currently "discussing whether or not to maintain CME accreditation." The data indicate that, while there may be multiple factors impacting intrastate accredited providers, the ACCME criteria and fees are considered problematic by more than 55% of providers. The results of this survey suggest that, if these issues are left unresolved, there likely will be a further reduction in the number of intrastate CME providers and in the number of CME activities certified for AMA PRA credit to serve physicians at the local level. Further decreases in the number of intrastate accredited providers could increase the already noted 14.6% decrease since 2003.

Survey of ACCME-Recognized State Medical Societies

In July 2009, the AMA conducted a second survey aimed at recognized state/territorial medical societies to better understand their views on the impact of accreditation fee increases, the ACCME accreditation criteria, and the new ACCME markers of equivalency. SMS were also asked to provide information about each CME provider whose accreditation has lapsed or been withdrawn since January 2007 and to include the reason(s) that these CME providers have not maintained accreditation.

The survey was sent to all SMS recognized by the ACCME at that time. It was in the field for a total of 23 days; those individuals that did not initially respond were contacted by email and phone to encourage participation. A total of 38 respondents who completed the survey were included in the analysis, for an approximate response rate of 83%.

The 38 SMS that responded to this survey accredit 1,463 intrastate CME providers. They reported that since January 2007, accreditation has lapsed or been withdrawn for 182 CME providers in their states. Reasons cited for providers no longer being accredited include:

Reason No Longer Accredited by SMS (more than one answer could be checked)	**Number**	**Percentage of Lapsed Providers**
Documentation/accreditation requirements too difficult	61	33.5%
Organizational merger/acquisition/closure	40	22.0%
Lack of physician participation	31	17.0%
Fees for accreditation/maintaining accreditation too high	23	12.6%
Will joint sponsor activities with an accredited organization	21	11.5%
Organization unable/unwilling to provide necessary resources	13	7.1%
Received SMS decision of non-accreditation	6	3.3%
Accredited by ACCME	5	2.7%
Cost/benefit analysis	5	2.7%
Other reasons	26	14.3%

This data affirm what was disclosed in the survey results from the intrastate providers. The accreditation requirements/criteria have become a barrier to continued accreditation. It should be

noted that, while fee increases did not rank as highly in this breakdown as compared to the survey of intrastate accredited providers cited above, this analysis represents a retrospective look at the past two years, which predates the announcement of the ACCME fee increases to SMS accredited providers. The survey of providers took into account the future ACCME fee increases and as a result the concern level regarding fees is much higher looking forward.

All recognized SMS charge intrastate CME providers for the accreditation services that they supply. The types of fees and the amounts charged by the states vary considerably. All but four of the SMS that responded to this survey already charge an annual fee to CME providers to maintain accreditation. The following is a summary of fees charged by SMS for accreditation:

1. Accreditation fees are charged by 28 states. 15 have a fixed rate for all providers ranging from a low of $200 to a high of $3,300, and 13 have variable rates that range from a low of $100 to a high of $6,500.

2. Survey fees are charged by 22 states. 10 have a fixed rate for all providers ranging from a low of $300 to a high of $2,500, and 12 have variable rates that range from a low of $0 to a high of $6,500.

3. Annual fees are charged by 34 states. 15 have a fixed rate for all providers ranging from a low of $75 to a high of $2,100, and 19 have variable rates that range from a low of $0 to a high of $5,250.

4. Progress report fees are charged by 13 states with a fixed rate for all providers ranging from a low of $50 to a high of $900.

5. Other fees are charged by 13 states for such things as late fees, extension fees, pre-application fee, surveyor expenses, and registration fees for conferences. Fees for these items range from a low of $150 to a high of $1,200.

While a few SMS may subsidize the accreditation services in part, most states set fees and budgets to at least break even and cover the costs of providing accreditation function. Such budgets are based on the state's average period of accreditation for providers. With the ACCME's mandate that periods of accreditation must be uniform, states with average accreditation periods that are less than the ACCME's will need to increase fees to maintain income levels to support the program. Comments from the survey related to fees included:

- "The new fee structure that the ACCME has instituted is very high and will make it impossible for some organizations to remain as providers";
- "The system of equivalency has played havoc with our finances and we have had to inform our providers of substantial fee increases (particularly for smaller providers) in order to maintain our self-funded status. ACCME was so intent on its own financial needs that it never saw state financial needs as a topic for discussion"; and
- "The SMS providers do approximately 1/3 of the CME activities nationally while their share of commercial support has dwindled to about 3%. That means providers are committing more and more of their own resources to the CME effort to cover the increases in the expenses. In effect, the SMS providers already do CME as a form of philanthropy, and it just seems tone-deaf to increase the fees, even by a few hundred dollars. Not to mention that the economic timing is horrible."

Whereas the survey of providers examined expectations concerning the difficulty in documenting compliance with the 22 ACCME criteria, the SMS were asked to opine as to whether each of the criteria adds value, neither adds nor reduces values, or reduces value to the accreditation process. All but two of the individual criteria were rated by 50% or more of respondents as adding value. The survey also included questions about each of the ACCME's five new Markers of Equivalency. SMS were asked to indicate whether each of the markers had been incorporated in their accreditation program, how easy or difficult was documenting compliance with each marker, and whether the marker added value to the recognition process. Seventy-six (86%) respondents indicated that all five of the markers had been completely incorporated in their programs, and the remainder reported that the markers had at least been partially incorporated. When asked about documentation, fifty-six (75%) of the SMS indicated that it was easy or very easy to document compliance with all of the five markers.

While the SMS did not appear to have a great deal of difficulty with either the individual criteria or the individual markers, the open-ended comments to the question "What else should the AMA take into consideration in preparing its report to the House of Delegates regarding the recognition of state accreditors and the accreditation of intrastate CME?" expressed significant concerns about the relationship between the ACCME and the SMS accreditation system. The most frequent of these responses focused on the ACCME's failure to meaningfully involve SMS in the development process or to allow them to vote or even comment before the criteria or markers were adopted. This is cited as having placed the SMS in a defensive position and has resulted in a sense of not having real ownership in the process. As one respondent indicated, "The point of equivalency was the idea that SMS accreditors would not have to 'reinvent the wheel;' that concept has not translated into a collaborative relationship with the ACCME. We do need to have a more collaborative discussion on the state system--how can we make the process easier for all of us?" The comments also express the concern that the ACCME does not fully appreciate the unique role and resource limitations of intrastate CME providers, nor for that matter, the resource burden of the SMS in maintaining a CME accreditation program. There is also a feeling that, taken as a whole, many of the criteria are duplicative, onerous, and may be unnecessary; and there is frustration that the ACCME's interpretations of compliance are continuously changing.

ACCME ACTIONS IN RESPONSE TO AMA AND OTHER STAKEHOLDERS

Even before the above referenced surveys were conducted/analyzed, the Council on Medical Education identified several areas of concern related to not only the ACCME accreditation and recognition processes but also to the governance of the ACCME itself. The AMA has systematically evaluated various issues and initiated a series of communications with the ACCME and its member organizations to bring about change. These efforts included:

1. A June 2008 request for the ACCME to include determination of compliance with AMA PRA credit requirements as part of the accreditation process.

2. A July 2009 request for the ACCME to reconsider its proposed fee increases in response to Resolution 312 (A-09).

3. An October 2009 request for the ACCME to change its accreditation criteria interpretation so that knowledge-based activities would be compliant with accreditation criteria.

The AMA also participated in a stakeholders meeting, convened by the ACCME Board of Directors, in December 2009 at which the AMA's, as well as other organizations, concerns about the ACCME accreditation process were shared with that Board.

The ACCME has responded with several positive actions, which may indicate a new era of collaboration and transparency between the ACCME and its stakeholders. The Council acknowledges and appreciates the work of the ACCME Board in facilitating these changes. Specifically, in response to AMA's request related to monitoring for compliance with AMA PRA credit requirements, the ACCME Board approved, in principal, the incorporation of the review of "Monitoring of Activity-Specific PRA Compliance" into the ACCME's accreditation process, and asked staff to construct the details of this incorporation and draft a "memorandum of understanding" in collaboration with the AMA.[7]

Relevant to the fee increases, the ACCME BOD has delayed implementation of the $550 SMS accredited provider fee by two years through the implementation of an incremental increase schedule of $80 in 2010, increasing to $250 in 2011, to $450 in 2012, and to $550 in 2013.[7] With regard to AMA's request concerning knowledge-based CME, the ACCME has communicated to the AMA that it shares the view that education designed to change knowledge is of great importance and that the ACCME recognizes that knowledge is the underpinning to any other learner's change. The ACCME Board acknowledged that the 2006 criteria may not have been clear in this regard and has directed ACCME staff to begin a dialog with AMA to be sure that knowledge-based activities continue to be part of accredited continuing medical education. In addition, on
January 22, 2010, the ACCME issued a call for comments throughout the CME community for feedback related to this issue.

On that same date, a similar call for comments was issued by the ACCME to gather opinions regarding the process for recognizing state and territory medical societies as accreditors. The ACCME has promised to publish the comments that it receives relevant to these calls for comments but that information was not available at the time of the writing of this report.

The December 2009 stakeholders meeting convened by the ACCME resulted in a report from the ACCME that indicates that, with regard to the 2006 criteria, the ACCME will consider strategies for reducing documentation requirements and clarifying the requirements. The ACCME will also continue to offer education and resources to assist providers with implementation of the updated criteria. The final comment of this report states: "The ACCME has a commitment to continuous improvement. The ACCME needs to receive ongoing feedback and reshape expectations. The ACCME has a strong commitment to following through with the information points collected in this roundtable discussion and thanks all participants. Similar meetings will be conducted on at least an annual basis and the ACCME will communicate its progress in addressing the above initiatives and concerns to stakeholders on a regular basis."[7]

Also, effective with the December 2009 ACCME Board meeting, member organizations' staff liaisons will be invited to participate in meetings of the full Board.

The Council on Medical Education recognizes that this is just a beginning but is heartened by the responsiveness of the ACCME Board. The Council expects to continue this positive dialog with the ACCME regarding important issues related both to the accreditation and recognition processes to insure that these result in quality, accessible, affordable CME that also meets the requirements for AMA PRA credit.

SUMMARY AND CONCLUSIONS

The AMA has a long history of advocating for local CME and for the state medical societies who serve as accreditors of the intrastate CME providers that produce CME activities. The studies show that the threat to the continued sustainability of the SMS CME system is real. The combined effect of the ACCME updated criteria, markers of equivalency, and increased fees for intrastate providers is that a significant number of local CME providers have left the system or are contemplating doing so in the future.

It is not clear that the fees that the ACCME proposes to charge intrastate providers are commensurate with the services that ACCME provides to the SMS system. The ACCME has created confusion in the CME environment by changing its interpretations of the accreditation standards. Where the ACCME and AMA once shared common definitions about activities that could be awarded *AMA PRA Category 1 Credits* ™, the ACCME has adopted new terms and requirements that no longer fit with the AMA PRA system.

The Council on Medical Education believes that the recent actions taken by the ACCME BOD indicate that the ACCME is serious about working with CME stakeholders, including the AMA and other ACCME member organizations, to address concerns regarding the costs/resources required for CME provider accreditation and state recognition, the complexity/bureaucracy associated with these processes, the efficacy of the accreditation criteria and markers of equivalency, and the connection of ACCME accreditation to the AMA PRA credit system. It is evident that the ACCME Board efforts have resulted in some positive changes, and the Council anticipates that AMA's continued collaboration with ACCME leadership will help to insure that the ACCME of the future continues to be responsive to CME stakeholders in its manner of acting.

RECOMMENDATIONS

Therefore, the Council on Medical Education recommends that the following be adopted and that the remainder of this report be filed.

1. That our American Medical Association (AMA) communicate its appreciation to the Accreditation Council for Continuing Medical Education (ACCME) Board of Directors for their responsiveness to AMA's requests this past year. (Directive to Take Action)

2. That our AMA continue to work with the ACCME to: a) reduce the financial burden of institutional accreditation and state recognition; b) reduce bureaucracy in these processes; c) improve continuing medical education, and d) encourage the ACCME to show that the updated accreditation criteria improve patient care. (Directive to Take Action)

3. That our AMA continue to work with the ACCME to a) mandate meaningful involvement of state medical societies in the policies that affect recognition and b) reconsider the fee increases to be paid by the state-accredited providers to ACCME. (Directive to Take Action)

4. That the Council on Medical Education monitors the results of the aforementioned recommendations with a report back to the House of Delegates at the 2011 Annual Meeting. (Directive to Take Action)

Fiscal Note: $1,500 for staff time.

Appendix A

Providers Responses to Question: "What else the AMA should take into consideration in preparing this report for the HOD?"

Administrative burden – The financial and staff resources necessary for the entire accreditation process are a concern to many providers. This includes the process of reaccreditations, such as preparing the self-study, as well as what is involved in certifying activities for *AMA PRA Category 1 Credit*™. Some of the burden comes from implementing the new ACCME criteria. Much of it was expressed from the viewpoint of small, community hospitals.	128
Accreditation criteria – Many providers find documenting compliance with the new criteria challenging, especially in the areas of gaps and measuring changes in behavior, competence, or outcomes.	73
Fee increase – Increased fees, especially in a time of economic downturn, are a concern. Some question whether there is added value for the added cost.	47
Not "one size fits all" – Providers in this category feel that the criteria are more suited to certain types of organizations than others, and some go on to say the accreditation process should have the flexibility to reflect this.	29
Relationship with state accreditor – The majority in this category expressed appreciation for the help and education their state medical society gives providers; however, a few expressed a wish for more guidance/education/collaboration.	20
Outside competition for physician attendees – With the ease of obtaining *AMA PRA Category 1 Credit*™ from a variety of easily accessible sources, many providers feel this competition reduces the physician attendees at their activities.	20
More guidance/clarity on how to meet & implement criteria/documentation requirements – Providers are struggling with understanding and knowing how to meet all requirements, and many stated a need for more clarification and guidance. Examples and forms would be helpful.	19
Commercial Support – The majority of comments (12) were in favor of commercial support, and many mentioned that it is much more difficult to find. Five indicated commercial support should be curtailed or eliminated.	17
Economic situation in state/US – Some providers just mentioned the economy without other qualifying statements, while others spoke of resulting budget constraints.	14

REFERENCES

1. List of CME providers accredited by ACCME (updated 1/22/2010); List of CME providers accredited by a state medical society (updated 1/22/2010); List of Recognized State Medical Societies. Accessed on February 22, 2010 at www.accme.org.
2. Accreditation Council for Continuing Medical Education Bylaws, January 1, 1981.
3. Accreditation Council for Continuing Medical Education Bylaws, Current Bylaws. Accessed on February 22, 2010 at www.accme.org.
4. Accreditation Council for Continuing Medical Education 2008 Annual Report Data. Accreditation and Annual Report Data
5. Accreditation Council for Continuing Medical Education Updated Accreditation Criteria. Accessed on February 22, 2010 at www.accme.org.
6. Accreditation Council for Continuing Medical Education Markers of Equivalency. Accessed on February 22, 2010 at www.accme.org.
7. Accreditation Council for Continuing Medical Education Executive Summary of the December 2009 Meetings of the ACCME Board of Directors. Accessed on February 22, 2010 at www.accme.org