REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 9-A-11

Subject: Opposition to Increased CME Provider Fees

Presented by: Baretta R. Casey, MD, MPH, Chair

This is an informational report that responds to Policy D-300.980, (AMA Policy Database), "Opposition to Increased Continuing Medical Education (CME) Provider Fees," adopted by the House of Delegates (HOD) that asked:

> 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;
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> That our AMA continue to work with the ACCME and the American Osteopathic Association 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;
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> That our AMA 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; and
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> That the Council on Medical Education monitor the results of the aforementioned recommendations with a report back to the HOD at the 2011 Annual Meeting.

BACKGROUND

The AMA is a founding member of the ACCME and has linked its American Medical Association Physicians Recognition Award (AMA PRA) Category 1 credit system to ACCME by requiring that US organizations that wish to designate and award *AMA PRA Category 1 Credit*™ be first accredited by the ACCME or a state medical society (SMS) recognized as a state accreditor by the ACCME. This privilege is not accorded to any other US accreditation programs.

There are 2,161 CME providers accredited through the ACCME system. While 695 (32%) are accredited directly by ACCME, 1,466 (68%) intrastate CME providers are accredited by the 45 SMS recognized by ACCME. The majority of SMS-accredited providers are community hospitals. According to ACCME, in 2009 SMS-accredited CME providers produced approximately 33.6 % (48,212) of all activities that were certified for *AMA PRA Category 1 Credit*™. Licensing boards, specialty certification boards, and other credentialing bodies accept *AMA PRA Category 1 Credit*™ for the purpose of meeting their CME requirements.

Council on Medical Education Report 14-A-10 responded to Policy D-300.982, "Opposition to Increase CME Provider Fees," that asked for the AMA to study and report back at the 2009 Interim Meeting on the system of intrastate accreditation, including the ACCME fee structure for state

accreditors and their providers, the concept of equivalency and new criteria for compliance, and the impact these changes will have on state accreditors and their CME providers. CME Report 14-A-10 concluded that, "the studies show that the threat to the continued sustainability of the intrastate CME accreditation system is real." The report also stated that, "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 acknowledged that, "the recent actions taken by the ACCME Board of Directors (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."

CURRENT STATE OF THE INTRASTATE CME ACCREDITATION SYSTEM

The number of intrastate CME providers accredited through the SMS intrastate system has continued to decline. Data provided by the ACCME indicate that since 2003, intrastate CME providers have declined by 318 (1,784 providers in 2003 to 1,466 in January 2011), or 17.9%. The decrease for this past year is 52 CME providers (3.5%) (See Table 1).

Table 1. Decline of Intrastate Accredited CME Providers

Year	Number of Providers	% Change from 2003
2003	1,784	
2004	1,724	- 3.4%
2005	1,693	- 5.2%
2006	1,684	- 5.6%
2007	1,663	- 6.8%
2008	1,600	-11.3%
2009	1,518	-14.9%
2010	1,466	-17.9%

2003-2005 data are from ACCME correspondence to AMA; 2006-2009 data are from ACCME Annual Reports; and 2010 data are from an ACCME Web site posting as of January 2011.

The ACCME's most recent annual report for 2009 discloses that from 2008 and 2009, aspects of programming by intrastate providers also continued to decline in terms of the number of activities presented (5.7%), hours of programming (10.3%), and physician participants (1%).

Council on Medical Education Report 14-A-10 summarized the results of surveys of intrastate-accredited CME providers (1,323 surveyed/41% response rate) and recognized SMS (46 surveyed/83% response rate) conducted in 2009. Significant findings from the intrastate accredited CME providers survey were that:

1. 86% of intrastate CME provider 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. Only 1 CME provider (less than 1%) answered that providing AMA PRA credit was not important.

2. 60% of intrastate CME provider respondents indicated that the new ACCME criteria would make it more difficult to provide quality CME activities.

3. 59% of intrastate CME provider respondents indicated that accreditation fee increases were a factor that were very likely or somewhat likely to cause their organization to consider not being accredited in the future.

4. 34% of intrastate CME provider respondents reported that their organizations were "discussing whether or not to maintain CME accreditation."

To determine whether these findings had changed significantly since the 2009 surveys, in December 2010 and January 2011, the AMA surveyed the 45 SMS currently recognized by ACCME to accredit intrastate CME providers. Thirty-five of the 45 SMS accreditors (78%) replied to this survey. SMS representatives were asked to answer questions based on their knowledge of the multiple CME providers accredited through their intrastate accreditation programs in terms of whether certain statements were/were not issues in their state. Analysis of the responses from the recognized SMS accreditors indicates that:

1. CME providers documenting/complying with all accreditation criteria is a major issue for 40% of SMS and somewhat an issue for 57%. Only one SMS reported that this was not an issue.

2. ACCME fee increases scheduled for intrastate CME providers is a major issue for 35% of SMS and somewhat an issue for 41%.

3. Decrease in SMS-accredited CME providers in the state is a major issue for 26% of SMS and somewhat an issue for 57%.

4. SMS documenting/complying with equivalency requirements is a major issue for 15% of SMS, somewhat an issue for 32% and not an issue for 53%.

The Council notes that 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. As noted previously, intrastate CME providers produce over one-third of all activities that are certified for *AMA PRA Category 1 Credit*™.

It is of significant concern that the decline in the number of intrastate accredited providers, which are mostly community hospitals, is occurring at a time when hospital and other local CME providers, which have access to performance data, could be offering assistance to the physicians by implementing performance improvement continuing medical education (PI CME) that contributes to improving patient care and may be recognized for multiple data reporting purposes, including Maintenance of Certification (MoC®) and Maintenance of Licensure (MoL). It is conceivable that a further decline of the SMS accreditation system in the future may impede the delivery of cost-effective, quality, accessible certified CME that deals with local health care issues and impedes the ability of physicians to stay properly credentialed.

EXISTING AMA POLICY

Policy D-300.980, Recommendation 1: "That our 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."

Response to Recommendation 1: The AMA has made a consistent effort to acknowledge and thank the ACCME for their efforts in writing (August 17, 2010), in the opening statement by the Council on Medical Education Chair at the joint meeting with ACCME leadership on October 11, 2010, in presentations to the ACCME BOD by AMA's Director of Continuing Physician Professional Development (CPPD), and in regular meetings between ACCME staff leadership and the AMA's Vice President of Medical Education and CPPD Director.

Policy D-300.980, Recommendation 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."

Response to Recommendation 2: All of the issues outlined in this recommendation were conveyed to the ACCME in the Council's letter of August 17, 2010 and also were subjects of discussion in the October 11, 2010 meeting of the ACCME's and AMA's Council leadership. The issue of the financial burden is covered further in the next section of this report related to Recommendation 3.

AMA acknowledged at the October 11, 2010 meeting that ACCME had previously taken action to reduce bureaucracy in the accreditation process by eliminating duplicate questions in the self-study process related to the commendation criteria, but AMA representatives suggested that more work was needed to provide relief to CME providers by eliminating redundancy in the accreditation process and decreasing the documentation burden, while at the same time monitoring to ensure quality education.

The AMA noted changes made to the AMA PRA credit system to improve certified CME and offered to work with ACCME to evolve and align the accreditation and credit systems to improve physician CME. The AMA also noted at this meeting that, while the research supports that CME improves knowledge, skills and patient outcomes, additional research is needed related to the impact of the accreditation criteria on patient care. The spirit of this meeting was cordial and productive, and the AMA awaits the changes or initiatives that ACCME will undertake related to these issues as a result of the work of the ACCME's Accreditation Requirements Task Force.

On October 14, 2009, the Council relayed to ACCME its concerns with ACCME's interpretation related to what constitutes appropriate CME, which stated that: "Providers must understand that a 'knowledge' need must be translated into a change in competence or performance or patient outcomes in order to generate a finding of compliance." The Council expressed its concern that such interpretation would exclude important knowledge-based, academic, research-related CME as compliant with the accreditation criteria. Subsequently, ACCME communicated with the Council (January 4, 2010) that it shared the Council's view that education designed to change knowledge is valued and of great importance. The ACCME then proceeded, in January 2010, to issue a call for comments from the CME community to look at whether the word "knowledge" should be added to Criteria 1, 3 and 11. The overwhelming response (64%), which included a response from the AMA to the call for comments, indicated that the word "knowledge" should be added to Criteria 1, 3 and 11. In July 2010, AMA reiterated its request to add 'knowledge' to the criteria in correspondence related to Policy D-300.980.

The word "knowledge" was not added to criteria 1, 3 and 11. Instead, the Executive Summary of the ACCME BOD meeting of July 2010 states that, "With respect to Criteria 3 and 11, even if the preponderance of a provider's activities is focused solely on changing knowledge, the provider must still show that these activities contribute to the overall program's efforts to change learner's competence, or performance or patient outcomes." As an example of "Noncompliance" with Criterion 3, ACCME has posted on its Web site (as of September 22, 2010) the following finding: "Although the provider describes in its self-study report the generation of activities designed to change patterns of care and the application of new information, the examples presented in the self-study report and in the activities reviewed show evidence only of activities designed to change knowledge, not competence, performance or patient outcomes." Thus, while ACCME has indicated that knowledge-based activities are valuable CME, to date no changes have been made to the criteria and CME providers are still expected to evaluate a change in physician competence rather than a change in knowledge to demonstrate compliance with the accreditation criteria for knowledge-based activities. Continued concern regarding ACCME's interpretation of knowledge-based CME also was noted by 45% of the SMS responding to AMA's December 2010/January 2011 survey. Therefore, the issue may not be fully resolved.

Ongoing discussion between the AMA and the ACCME related to the ACCME's monitoring for compliance with *AMA PRA Category 1 Credit*™ requirements continues. In June 2008, the AMA requested that collaborative discussions be initiated noting that as the AMA PRA credit system and the ACCME accreditation systems have evolved over the years, it was no longer clear that the ACCME accreditation processes included sufficient monitoring for *AMA PRA Category 1 Credit*™ requirements. This is an issue since AMA has represented to stakeholders that certification of activities for *AMA PRA Category 1 Credit*™ represents that the activities meet the stated AMA PRA requirements.

In December 2009, the ACCME approved, in principle, the incorporation of the review of "Monitoring of Activity-Specific PRA Requirements" and discussions were initiated between AMA CPPD staff and ACCME staff. In June 2010, the Council followed up with the ACCME offering a "Proposed Pilot for ACCME to Enhance the *AMA PRA Category 1 Credit*™." The AMA offered to meet with the ACCME to explain the proposal and outline collaborative tasks. The ACCME has commissioned a Task Force to consider this issue. The AMA looks forward to being invited to participate in the ACCME's Task Force discussions and being apprised of any results from these deliberations.

Policy D-300.980, Recommendation 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."

Response to Recommendation 3: The issue of meaningful involvement of the SMS in developing policies for recognition was another subject of the October 11, 2010 joint leadership meeting referenced previously. AMA Council on Medical Education representatives encouraged the ACCME at that meeting to insure such involvement of all recognized SMS in the standards setting/policy development process. Results from the December 2010/January 2011 SMS survey indicate that 24 (73%) of the 33 states that responded to the question indicated that state involvement into accreditation standard setting is still either somewhat an issue or a major issue for their states.

During the October 11, 2010 meeting, Council representatives also noted the AMA's concerns that the ACCME's delay in implementing proposed fees had not mitigated concerns of intrastate CME providers regarding the financial burden of accreditation and recognition. Council representatives

specifically asked that the ACCME review the new fees for intrastate accredited CME providers and consider how they may be reduced or eliminated.

SUMMARY AND CONCLUSIONS

The AMA has a long history of advocating for local CME and for the SMS system that accredits intrastate CME providers that, in turn, produce CME activities that are certified for *AMA PRA Category 1 Credit*™. The Council on Medical Education has monitored results of the recommendations from its Report 14-A-10 and recognizes that the ACCME Board of Directors has been amenable to discussing AMA concerns and has even appointed workgroups to address solutions. That said, the new fees for intrastate-accredited providers that the ACCME has proposed, though delayed, have not been reduced or eliminated.

While some actions have been taken to eliminate some documentation for commendation criteria, the Council agrees with the ACCME BOD that documenting/complying with all accreditation criteria continues to be an issue for CME providers and looks forward to further improvement. Although the ACCME has agreed that knowledge-based CME may be included in an accredited CME program, changes to the ACCME criteria to reflect this have not been implemented, and as a result CME providers continue to struggle with how they will document a change in competence for these activities. Finally, the ACCME work to establish a monitoring program that includes an audit of compliance with *AMA PRA Category 1 Credit*™ requirements is still in its early stages.

Previous AMA studies showed that the combined effect of the ACCME-updated criteria and increased fees for intrastate providers was the reason many local CME providers were considering withdrawing from accreditation. The continued annual decrease in the numbers of state CME providers confirms that this is, in fact, occurring. The Council recognizes that if the ACCME/SMS accreditation process is too costly or burdensome, there may be fewer local CME providers willing to maintain accreditation in order to provide CME activities that are certified for *AMA PRA Category 1 Credit*™. Further, if the ACCME/SMS accreditation process does not demonstrate that AMA PRA standards and the educational value that they bring to certified CME activities, as has been represented to physicians, credentialing bodies, and the public, are being met through the accreditation process, it is conceivable that the credibility and utility of the AMA credit system could be negatively impacted in the future. While the AMA is very gratified with the communication from the ACCME BOD and its expressed desire to make changes to address these issues, given the slow pace of change, we will have to be diligent in tracking the ACCME's progress in these areas.