Alliance for
Continuing Education
in the Health Professions

IME Policy Update With the CME Coalition

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In addition to directing the CME Coalition since 2011, Andrew Rosenberg is co-founder and co-leader of Thorn Run Partners. Launched in 2010 as a two-person boutique, Thorn Run is today recognized as one of the largest and most impactful government relations and strategic communications firms in the country. Prior to starting Thorn Run, Rosenberg spent a combined two decades on the staff of Senator Edward M. Kennedy (D-MA) and as a policy lawyer, public affairs specialist, and lobbyist at several of Washington's top firms.

Thomas Sullivan

Tom Sullivan, formerly CEO of Rockpointe and the Founding Member of the CME Coalition, is a healthcare policy & communications executive who brings over 25 years of experience in medical education and program development working with organizations such as the American Heart Association, American Lung Association, American College of Cardiology, American Diabetes Association, National Multiple Sclerosis Society, American Society of Clinical Oncology.

Shea McCarthy

Shea McCarthy is a seasoned operator in the sphere of federal advocacy. As a Partner at Thorn Run Partners and coordinator of the firm's multidisciplinary policy team, Mr. McCarthy advises clients on the intricacies of health care policy, develops sophisticated government relations strategies, and has successfully influenced the implementation of numerous federal laws.

About the CME Coalition

- For 15 years, the CME Coalition has served as the only trade association in Washington, DC devoted exclusively to advancing the interests of accredited continuing medical education.
    - Our mission is to educate federal policymakers on issues related to the provision of CME, counsel CME stakeholders on compliance-related matters, and advocate for sensible federal, state, and stakeholder policies to advance its practice.
- Our membership spans the full continuing education ecosystem:
    - **Providers of accredited education:** medical education companies, publishers, and technology platforms
    - **Beneficiaries of CME:** academic medical centers, health systems, and professional societies
    - **Supporters of CME:** pharmaceutical and medical device manufacturers
- The work is practical and continuous — tracking federal and state legislation, engaging agencies and accreditors, convening member working groups, and translating policy shifts into guidance our members can act on.

Our Members Currently Include

Our Discussion Today Includes…

I. Capitol Hill Update
   - Year-end priorities and a review of CME-specific legislation

II. CME and the MAHA Agenda
   - How MAHA (Make American Healthy Again) policies and industry skepticism are reshaping the federal health agenda

III. Diversity, Equity, and Inclusion… and CME
   - Emerging DEI policies from the state and federal level

IV. Medicare/MIPS Reform
   - How reform is impacting the future of QI-CME

V. Emerging Issues
   - Changes in Federal public health data collection under Trump
   - Artificial Intelligence

I. Capitol Hill Update

The health policy landscape heading into the midterm elections.

The Remainder of the 119th Congress

- Congress has until September 30 to fund the government.
  - The House Appropriations Committee has reported all twelve of its FY 2027 bills; the Senate has yet to mark up any of its own.
- Senate Appropriations Chair Susan Collins (R-ME) has been upbeat on a continuing resolution **that funds the government past the midterms**. Broadly, "regular order" remains gridlocked over topline spending levels.
- A third reconciliation package remains unsettled. OMB Director Russell Vought has described the talks as keeping the bill "tight," and Majority Leader John Thune (R-SD) has said the House framework lacks the 50 votes it needs in the upper chamber.
  - Healthcare policy is unlikely to be affected by the provisions of this package.
- If the calendar holds, the House and Senate have roughly **12 overlapping voting days** between its August recess and the November general election.
- **Any outstanding healthcare legislation that passes this year will have to "ride" on a very small number of must-pass vehicles.**

Healthcare Policy in the 119th Congress

A number of federal healthcare programs and provisions are set to **expire at the end of the year,** and lawmakers will work to extend these programs in their dwindling session days. These programs and provisions include:

- The Advanced Alternative Payment Model bonus payment
- The one-time Medicare physician fee schedule conversion factor increase provided in reconciliation
- The clinical laboratory fee cut delay
- No Surprises Act implementation funding
- Funding for Community Health Centers; the National Health Service Corps; and Teaching Health Center GME

In addition to these funding priorities, **pharmaceutical policies** remain at the forefront of Congress and the administration. Legislation addressing a variety of issues could be positioned for a year-end vehicle:

- Codifying Most Favored Nation (MFN) policies and international reference pricing
- Increasing oversight of pharmacy benefit managers (PBMs)
- Reforming the 340B drug pricing program
- Policies to bolster price transparency, including: the Lower Costs, More Transparency Act of 2026 and the Medicare Advantage MLR Transparency Act

The CME Coalition *on Capitol Hill*

The Coalition's central message on Capitol Hill continues to be that accredited CME is a practical, scalable tool for advancing national health priorities. This year, that message landed.

- **Nutrition CME report language.** Working with Reps. Vern Buchanan (R-FL) and Andy Harris (R-MD), the Coalition secured dedicated report language on Nutrition CME in the House Appropriations Committee's FY 2027 Labor-HHS bill. The Committee encourages HHS to support accredited providers in developing, disseminating, and evaluating independent, evidence-based nutrition CME. The report also carries CME-relevant language in other clinical areas, including menopause education — evidence that Congress increasingly reaches for clinician education as a tool for closing practice gaps.

- **MACRA and MIPS.** The Coalition is meeting with lawmakers now to preserve QI-CME as a qualifying MIPS improvement activity as reform proposals take shape.

II. The MAHA Agenda

How the administration’s priorities are impacting education requirements.

MAHA Priorities

The Make America Healthy Again (MAHA) Commission is one of the most significant developments shaping CME in this moment. Its initial report, published last year, included pointed language about the influence of private industry, including industry-funded CME, in distorting medical knowledge.

Other key policy priorities of the MAHA movement impacting CME include:

Nutrition & Metabolic Health

- HHS has made overhauling nutrition education in U.S. medical training an explicit priority, with Secretary Kennedy and Education Secretary McMahon leading the effort and medical schools signing on.

Fertility & Women's Health

- A priority of the administration, menopause and midlife health is now a central CME topic for several states.

Vaccines

- Federal vaccine policy continues to be fluid, and a recent Presidential executive order directed the CDC to reassess the childhood immunization schedule.
- Several professional societies, including the AMA, have been disinvited from CDC vaccine workgroups.
- Recent reporting has also indicated that the AMA is at odds with Secretary Kennedy over the administration's vaccine policies.

MAHA Priorities: State Action

As the priorities of the MAHA movement have become increasingly central to the administration's policies, HHS now reports that **42 states have also enacted MAHA-adjacent legislation.**

Key MAHA legislation related to CME requirements moving in the states include:

- Iowa HF 2676, the Governor's "MAHA" bill, adds at least one hour of nutrition and metabolic health CE every four years, applicable July 1, 2027, and requires Iowa medical schools to provide at least forty hours of nutrition coursework for cohorts graduating after July 1, 2028.
- Numerous other states also have pending legislation related to requirements for nutrition and metabolic health, including: Louisiana, Texas, West Virginia, Pennsylvania, New York, Hawaii, and Tennessee
- Illinois SB 3325 lets qualifying perimenopause and menopause coursework satisfy the state's existing one-hour implicit bias requirement beginning January 1, 2027.
- Legislation in Michigan and Massachusetts regarding CME for fertility and women's health are also advancing.

III. DEI

How federal and state policies are moving in two directions at once.

DEI at the Federal & State Level

Federal Recissions

- Since entering office, President Trump's administration has **rescinded several initiatives promoting diversity, equity, and inclusion (DEI) in healthcare** and restricted funding for NIH grants related to DEI.
- Most recently, Do No Harm, an organization that seeks to identify identity politics in healthcare, released a report entitled, "The Ideological Capture of Continuing Medical Education."
- The EDUCATE Act (H.R. 3518 / S. 1811) would bar federal financial assistance to medical schools that adopt DEI-related policies.

State Expansion

- Meanwhile, several states are passing legislation to bolster implicit bias training and support cultural awareness.
  - **New York S 1063** — two hours of cultural awareness and competence coursework per registration period, required by July 1, 2026, with parallel hospital verification obligations.
  - **Virginia SB 22** — up to two hours of bias reduction and sickle cell disease CE, effective July 1, 2026.
  - **Illinois** — one hour of implicit bias awareness training per renewal period remains in force for all licensed health care professionals.
  - **California AB 241** — implicit bias content within the fifty-hour biennial requirement, now the subject of a petition before the Supreme Court.

CME "Implicit Bias" Mandate before the Supreme Court: *Khatibi v Lawson*

Plaintiffs (Do No Harm) argued that California's implicit bias training requirement (2019) violated their constitutional free-speech rights by compelling them to include discussion of implicit bias in CME courses taught by them when they would otherwise remain silent about such topic.

- The district court granted Defendants' motion to dismiss. The court held that teaching CME courses constituted government (rather than private) speech, and thus Plaintiffs had not stated a claim that the government had compelled them to engage in protected speech. The court noted: "If Plaintiffs disagree with the Legislature's judgment in passing A.B. 241 [the law requiring implicit bias training], they can choose to no longer instruct CME courses for credit, as is their right, or err [sic] their grievances at the ballot box."

- The case has since been appealed to the Supreme Court which is expected to decide whether it will grant review (certiorari) or deny the case ahead of its upcoming term.

IV. MACRA / MIPS Reform

Medicare provider payment reform is moving — and the incentive for quality improvement CME is in play.

MACRA / MIPS Reform & the Future of QI-CME

- Medicare's value-based payment system **(MIPS) rewards physicians for activities that improve clinical practice** and patient care. One of those recognized activities is QI-CME, or CME that goes beyond education alone by helping physicians identify a gap in care, make changes in practice, and measure whether those changes improve outcomes.
- **That creates a direct policy incentive for participation in CME.** Under MIPS, CMS recognizes qualifying QI-CME as an Improvement Activity (IA_PSPA_28), giving physicians credit toward their Medicare performance score for participating in CME that is tied to measurable quality improvement.
- **CMS is now reshaping MIPS** around MIPS Value Pathways (MVPs).
  - The agency is moving toward more focused, specialty-specific measures and activities, with MVPs becoming the primary reporting pathway beginning in 2029.
  - **CMS is streamlining the Improvement Activities inventory.** The latest proposed rule from CMS would modify five activities and remove 11, but IA_PSPA_28 is not among those proposed for removal.
  - **That could make QI-CME more valuable, not less.** As CMS narrows the universe of qualifying measures and activities, an established activity that demonstrates measurable improvement in care could have a more prominent role in future MVPs.

CME Coalition priority: Preserve QI-CME recognition and ensure accredited performance-improvement CME remains part of the evolving value-based care framework.

Congressional Outlook for MACRA Reform

- **Congress is also rethinking how Medicare rewards quality improvement.** Bipartisan physician members of the House have begun work on modernizing MACRA and MIPS, including a Doctors Caucus request for information and a bipartisan House Energy & Commerce hearing on physician payment reform.
- The congressional proposal would fundamentally reshape MIPS.
  - The discussion draft would create a new CMS Quality Care Reform Task Force and move toward more streamlined reporting and automated extraction of quality data from EHRs and billing systems.
  - Importantly, the discussion draft does not appear to eliminate QI-CME directly.
- The potential risk is how the new system measures improvement. As reporting becomes more automated and increasingly dependent on EHR and claims data, **activities that are not readily captured in those systems — including participation in CME — could become harder to recognize**.
- That creates an opportunity for QI-CME. Congressional physician caucus staff have indicated support for continuing QI-CME credit, and the Coalition is working to ensure accredited performance-improvement CME remains part of any future Medicare quality framework.

V. Emerging Issues

Federal public health data collection and the role of AI.

Federal Data Collection Tracking Project

What we are tracking...

Since 2025, federal agencies have removed, discontinued, or narrowed several public health data collections. **The Coalition launched a comprehensive tracking project** to document these changes across agencies and continues to update it as new developments emerge.

- **CDC's National Center for Health Statistics Data Query System**
- **SAMHSA's National Survey on Drug Use and Health**
- **HRSA's Uniform Data System**.
- **CMS's Medicare Current Beneficiary Survey**

Why it matters for CME...

- Accredited providers are required to document professional practice gaps, and longitudinal federal datasets are how many of those gaps have historically been demonstrated.
    - When a series is discontinued rather than revised, the baseline disappears with it. A gap that cannot be measured is difficult to justify educating against.
- The effects are hardest on demographic and disparity-linked practice gaps, which is precisely the content already under pressure from the federal DEI rollback.
- **What we are asking.** Tell us which datasets your organization actually relies on, so we can prioritize what to track and where to press for restoration.

The Role of AI

Congress & the States

- **Federal policy remains fragmented.** Several health AI bills are pending, including the HEALTH AI Act (H.R. 5045), the AI in Health Care Efficiency and Study Act (H.R. 7064), and bipartisan legislation addressing AI-driven prior auth denials.
    - Broader federal AI legislation is increasingly likely to move into the 120th Congress.
- **States are filling the gap, with more than a dozen health AI laws enacted in 2026.**
    - Most target payers, but several reach providers directly: Maine restricts mental health professionals to administrative AI use, Arizona requires informed consent, and Delaware bars AI entities from professional licensure.

ACCME

ACCME is establishing clearer expectations for AI use in accredited continuing education. It issued *Guidance on the Responsible Use of AI in Accredited CE* on January 30, 2026, followed by an *Urgent Alert* on April 14.

- **Core expectations:**
    - the same independence and content-review standards for AI-generated material as for human-authored content;
    - disclosure of the tool, version, date, and purpose;
    - named, qualified human review for accuracy & hallucinations;
    - learner privacy protections; and
    - internal governance.
- **The Urgent Alert went further for AI-enabled activities**:
    - pre-deployment validation and defined guardrails;
    - a clinician in the loop with authority to intervene;
    - learner transparency and ongoing monitoring; and
    - vendor agreements preserving provider oversight.

Documentation is required, and accreditation is at stake.

What We're Watching

- **September 30 funding deadline:** whether the Nutrition CME report language is retained in the final FY 2027 Labor-HHS bill and accompanying report.
- **Supreme Court action in Khatibi:** what the Court's disposition signals for the durability of state-mandated CME content requirements more broadly.
- **MACRA reform:** how CMS's move toward MVPs and streamlined Improvement Activities — alongside the Doctors Caucus effort to modernize MACRA — could shape the future role of QI-CME.
- **2027 state legislative sessions:** continued activity around nutrition and metabolic health, menopause and midlife health, and bias-reduction CME requirements.
- **Federal anti-DEI policy:** whether restrictions now affecting admissions and graduate medical education extend into accredited continuing education.
- **ACCME and AI:** how the April Urgent Alert is applied in practice, particularly during accreditation reviews and enforcement.

Questions?

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Thank You

On behalf of the CME Coalition, we hope this was informative. Questions?

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