



Mr. Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Acting Administrator Slavitt:

It is our pleasure to submit these comments on behalf of the CME Coalition (www.cmecoalition.org), an advocacy organization comprised of nearly three-dozen organizations of continuing medical education (CME) providers, commercial supporters and medical specialists, regarding the final rule to implement the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

INTRODUCTION

We are writing to request that CMS continue to explore the potential role that continuing medical education (CME) can play as a clinical practice improvement activity. We appreciate the fact that in its final rule, CMS acknowledged the several hundred comments it received on the proposed rule encouraging the inclusion of CME as an “improvement activity,” and would like to engage with CMS, on behalf of our members, in the hopes of including CME in the 2018 proposed physician fee schedule to be released in July 2017.

Indeed, we continue to believe that the Centers for Medicare & Medicaid Services (CMS) explicitly recognize qualifying continuing medical education (CME) as a clinical practice improvement activity within the Merit-Based Incentive Payment System (MIPS). CME has long been recognized as an effective means by which physicians continue their professional development and practice improvement. Today, CME is a leading means by which physicians develop and maintain the knowledge, skills, and practice performance that leads to improved performance and optimal patient outcomes. The entire purpose of CME is wholly consistent with the goals of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

Accredited CME activities that are designed to further the objectives of MACRA can and should result in credit as clinical practice improvement activities within the MIPS.

LITERATURE REVIEW OF CME CASE STUDIES

We recommend that CMS explicitly acknowledge and provide credit for certain CME activities, provided by a nationally recognized accreditor (or accreditors), as clinical practice improvement activities within the Merit-Based Incentive Payment System. The appropriateness and effectiveness of CME as a means to accomplish this end is supported by a strong body of literature that demonstrates the effectiveness of CME, and particularly of performance improvement CME (PI-CME), on physician performance and patient health outcomes.

For your consideration, we suggest the following case studies:

- Cervero RM, Gaines JK. The impact of CME on physician performance and patient health outcomes: an updated synthesis of systematic reviews. *J Contin Educ Health Prof.* 2015 Spring;35(2):131-8. doi: 10.1002/chp.21290. Review. PMID: 26115113

This article synthesized systematic review literature on CME effectiveness published since 2003. Five of eight studies concluded that 1) CME does improve physician performance and patient health outcomes; and 2) CME has a more reliably positive impact on physician performance than on patient health outcomes.

It is important to note that this study went beyond asking whether CME had an impact on change in physician knowledge and competence. The focus was on higher-level educational effectiveness: improvements in physician performance (what the doctor actually does in clinical practice) and on patient health outcomes.

- Sutton LM, Geradts J, Hamilton EP, et al. CHAMBER: A Regional Performance Improvement CME Initiative for Breast Cancer Health Care Providers. *J Natl Compr Canc Netw.* 2015 Aug;13(8):1005-11.

Eleven of 18 clinicians who treat patients with breast cancer completed a three-step performance improvement CME (PI-CME) activity. The steps include an initial clinical practice assessment, educational activities, and a reassessment. A total of 208 patient charts were entered at the initial assessment. At the reassessment, 196 charts were entered. Chart review revealed a high rate of HER2 testing (98%) before and after education.

Targeted therapy for patients with HER2+ breast cancer declined after the program (from 96% to 61%), perhaps attributable to an increase in awareness of medical reasons to avoid use of targeted therapy. Assessment for patients' emotional coping ability increased after education (from 55% to 76%; P=.01).

This study demonstrated that clinicians follow protocols in testing, but that CME activities had a positive impact on healthcare provider practice regarding medical and emotional treatment of patients with breast cancer.

- Bird GC, Marian K, Bagley B. Effect of a performance improvement CME activity on management of patients with diabetes. *J Contin Educ Health Prof.* 2013;33:155-163.

509 family physicians assessed 11,538 patient charts for eight data elements based on the AMA's physician Consortium for Performance Improvement measurement set. Learners selected interventions for improvement. Reassessments took place in different learner cohorts at 1-3 months, 4 – 6 months, 7 – 9 months, and 10- 12 months. This study demonstrated improvement in both procedural performance, and in systems-based practice measures of physician learners as a result of their completion of the education.

Learners showed in aggregate strong improvement (>13%) in the number of patients who received appropriate diabetes care related to foot examinations, flu vaccination, and in coordination of care for diabetic retinopathy screening from baseline to follow-up. The data was encouraging as the entire activity was based on a plan-do-study-act (PDSA) design, and results were drawn from just the initial cycle.

- Marshall JL, Cartwright TH, Berry CA, et al. Implementation of a performance improvement initiative in colorectal cancer care. *J Oncol Pract.* 2012; 8:309–314.

540 patient charts were reviewed by 27 clinicians. Topics assessed through a review of patient charts included 22 topics, among them patient safety and supportive care, evidence-based surveillance, and evidenced-based treatment. The topics were derived from guidelines and other successful QI initiatives. The clinicians (89% of whom were MDs) selected their areas for improvement, with 23/27 focusing their improvement plans on patient safety and supportive care. As a result, quantified assessments of patient pain increased by 30%, and psychological assessments of CRC patients increased by 34% after completion of the program.

Participation in this program had a clear impact on the practices of those physicians who sought to improve the quality of their supportive care practices. It did not measure responsive actions by oncologists who determine that a patient is in need of emotional and psychological support.

- Shershneva MB, Larrison C, Robertson S, Speight M. Evaluation of a collaborative program on smoking cessation: translating outcomes framework into practice. *J Contin Educ Health Prof.* 2011; 31(Suppl 1):S28–36.

Nearly 43,000 clinicians participated in a multi-part initiative on smoking cessation. Three of the activities were PI-CME. Performance outcomes of the 3 PI activities varied, with greater improvements observed in one activity (9.0% to 36.2% improvement across 8 measures). Lower clinician performance outcomes were observed in the 2 other PI activities. However, these two PI CME activities observed a smoking quit rate of 231/494 patents, or 46.8%.

- Zisblatt L, Kues JR, Davis N, Willis CE. The long-term impact of a performance improvement continuing medical education intervention on osteoporosis screening. J Contin Educ Health Prof. 2013 Fall; 33(4):206-14.

The purpose of this study was to determine whether a performance improvement continuing medical education (PI CME) initiative that utilizes quality improvement (QI) principles is effective in producing sustainable change in practice to improve the screening of patients at risk for osteoporosis. The percentage of tests for osteoporosis ordered and performed increased significantly from Stage A to Stage C of the PI CME activity and continued to increase after the completion of the PI CME activity. Follow-up data at 4 and 40 months (for ordering and performing osteoporosis screening) and 49 months (for performing the screening only) reflect the impact of the PI CME activity plus the continuing QI interventions.

This study's major contribution to the literature is to demonstrate that PI CME education has the capacity to promote embedded change in learners that lasts well beyond the end of the original educational intervention.

In sum, our review of CME case studies revealed that as physician practice becomes more team-based, individual performance improvement occurs in the quality improvement context. Both PI and QI take a systems view to improvement, aim at improving human or organizational performance by addressing the gap between the present state and the desired state, and assert the need for data (Bornstein T, Quality improvement and performance improvement: different means to the same end? QA Brief. 2001 Spring; 9(1): 6-12).

CONCLUSION

The CME Coalition is a national coalition comprised of stakeholders from across the CME landscape. We appreciate this opportunity to offer our thoughts and suggestions on this important topic and hope our perspective is helpful to you as CMS executes on the promise of MACRA. We look forward to continuing to work together with CMS and other stakeholders in furtherance of these efforts.

We look forward to working with you and your staff in the coming month.

Sincerely,

Andrew Rosenberg
Senior Advisor
CME Coalition