

MEMORANDUM

TO: Board of Medical Practice

FROM: David Herlihy, Director, Board of Medical Practice

DATE: December 2, 2016

SUBJECT: Auditing Licensee Certification of Compliance with CME Requirements

1. Background.

a. Until the passage of Act 60 of 2011, physicians were not required to complete continuing medical education (CME) as a condition of renewing their MD licenses. The law created a minimum requirement of 10 hours of CME and called upon the Board to establish rules regarding further requirements. The law also specified that the Board should require evidence of professional competence on treatment options such as hospice, palliative care, and pain management services. The statute instructed the Board to have a rule in effect by August 31, 2012. By law, the requirements were to apply to licenses expiring after August 31, 2014. All Vermont MD licenses expire on November 30 of even-numbered years, so the requirement was in place for the first time during the renewal period for licenses that expired on November 30, 2014.

b. CME Requirements. As noted, the statute sets a minimum requirement of 10 hours per licensing period. Through rulemaking, the Board set the requirement at 30 hours per two-year licensing period. The Board also added a subject-specific requirement; if a licensee has a DEA license to prescribe controlled substances, he or she must complete at least an hour of CME on safe prescribing. That is in addition to the above-mentioned hour on treatment options such as hospice, palliative care, and pain management, which is found in the law. The requirements originally set forth in the law were modified again in 2016. Pursuant to Act 173, licensees who hold a DEA license will need to complete at least 2 hours of CME on controlled substances that covers: abuse and diversion, safe use, appropriate storage and disposal, use of the Vermont Prescription Monitoring System, risk assessment, pharmacological and non-pharmacological alternatives to opioids, tapering and cessation of controlled substances, and State and federal laws and regulations on opioid prescribing.

c. Qualifying CME Activities. By rule, the Board recognizes only CME activities that are approved for American Medical Association Physician's Recognition Award Category 1 Credit™ (AMA PRA Category 1 Credit™). The AMA PRA system is a program that vets CME activities to establish that standards for quality and independence from commercial interests are followed. It is the system used throughout the United States for recognition of CME activity.

d. Administration of the Requirement. To qualify to renew, a licensee must do one of the following:

- Certify compliance with the CME training requirements.
- Certify that he or she is exempt from the requirements for one of the reasons established in the rule (newly licensed or on a military activation for a significant portion of the period).
- Submit a make-up plan than meets the requirement of the rule.

Licenses are not required to submit documentation of their CME activities at the time of renewal. In accordance with the rule, licenses are subject to audit. The Board did not audit compliance related to the 2014 renewal process.

2. Proposal for Audit Process. It is proposed that the Board adopt the following audit plan to check compliance with the CME requirements.

a. Licensees will be selected for audit by creating a spreadsheet with the names of all licensees who certified compliance with the CME requirements by completing required activities. The list will not include licensees who were required to do a make-up plan for late completion of CME. An automated process will be use to randomly assign numerical values to each line of the spreadsheet. Those licensees with the lowest numerical values will be selected. If a licensee selected for audit has subsequently surrendered his or her license, or is deceased or incapacitated, the next lowest name will be added.

b. The number of licensees to be audited using this process is 59. If the number of licensees who fail the audit is 6 or more of the sample group of 59, the process will be repeated with a sample group of 93. The results of a second group will be presented to the Board for consideration. Staff will determine if a licensee passes the audit based upon whether the licensee provides satisfactory documentation of an adequate number of hours of activity that meet the requirements of the Rule.

c. Staff shall request documentation from at least 50% of licensees who rely on a make-up plan to meet the requirements.

d. These procedures for random audit do not apply to instances in which staff or the Board request documentation of CME activities for an identifiable reason.

e. Licensees who are found to have certified compliance with CME and who are unable to document the required activities will be referred for review by an investigating committee of the Board for a determination as to whether there is a basis for discipline for unprofessional conduct.

3. Basis for Sample Size. The proposal for the initial sample size of 59 and, if needed, a second sample of 93, is based upon written guidelines from the American Institute of Certified Public Accounts and informal consultation with the Vermont State Auditor's Office. Determination of sample size depends in large part on the audit goals and assumptions. I identified the following goals and assumptions:

Goal 1: Perform an audit to promote honesty in certification of compliance.

Goal 2: Perform an audit to provide the Board data to understand if certification is an adequate means of attaining compliance, or if the Board should consider a requirement for documentation from all licensees.

Goal 3: Avoid creating a burden for a greater number of licensees than necessary and avoid using more Board resources on an audit than necessary.

Assumption 1: There is a high compliance rate. 90% of MD licensees have self-reported as specialty board certified (they must submit documentation if board certified at the time of initial licensure, but we do not monitor or document maintenance of certification (MOC)). Most specialties require more than 15 hours of CME per year to maintain certification. Regardless of that existing requirement, there is no basis to suspect physicians are dishonest in reporting compliance.

Assumption 2: There is not a high risk associated with a failure to identify non-compliance. While CME is assumed to support good practice, there is not an immediate risk to patients posed based only on a physician's failure to engage in CME activity.

Because we know that 90% of the group has MOC as an incentive to complete CME, it is reasonable to conclude that the expected rate of non-compliance for that group is zero or very close to zero. Even if 10% of the 10% without board certification were non-compliant, the overall rate of deviation across the entire group would be 1% or less. For a sample size of over 2,000 and an expected deviation rate of zero, a sample of 59 yields a result with a 95% confidence rate. For a sample size of over 2,000 and an expected deviation rate of 1%, a sample size of 93 yields a result with a 95% confidence rate. (Based on AICPA Guidelines, Table 3.3 at ¶ 3.56).