Draft Meeting Summary

Physician Maintenance of Certification Work Group

Maryland Health Care Commission

Meeting of June 19, 4:00 PM to 6:00 PM

MHCC Offices, 4160 Patterson Avenue, Baltimore, MD

Committee Members in Attendance:

Ben Steffen

Megan Renfrew

Steve Wise

Jen Witten

Erin Dorrien

Katie Wunderlich

Dr. Dan Morhaim

Deb Rivkin

Tinna Quigley

Dr. Christina Stasiuk

Presenters:

Dr. Manuel Casiano

Dr. David Price

Other Individuals in Attendance:

Kim Robinson

Rianna Matthews-Brown

Karey McDonough

Dr. Paul Teirstein

Lindsay Rowe

Pegeen Townsend

Welcome and Introductions

Megan Renfrew started meeting. Ben Steffen welcomed all participants and lead a round of introductions both for group members, audience members, and people accessing the meeting remotely.

Work group charge and meeting objectives-Megan Renfrew, MHCC

Megan Renfrew, MHCC, reviewed the work group's purpose. She described Chairperson Pendergrass's letter to MHCC requesting the workgroup as a response to the withdrawal of HB 857 from consideration in the House Health and Government Operations Committee during the 2018 legislative session. This work group is advisory and our work product will go to MHCC for review and approval before being sent to the legislature.

In this meeting, the goal is to establish some shared knowledge through several presentations, and have time for discussion and public comment. Two more meetings are planned this summer. The hope is that these three meetings will be sufficient to allow us to define areas of agreement and develop findings and recommendations.

In August, Megan plans to write up the final work product, share it with the group for comment, with the goal of having a final document for review in the September meeting.

MOC in Maryland: Overview-Megan Renfrew, MHCC

Megan Renfrew reviewed the current legal context with respect to maintenance of board certification in Maryland. She noted that there is currently no legal restriction in Maryland in how hospitals and insurers may use Board Certification in credentialing, privilege, payment, and similar decisions. The Board of Physicians may not use specialty certification or maintenance of certification (MOC) as a qualification for licensure (Health Occupations 14-322).

She described the entities that offer Board certification that are most relevant to the work of this workgroup, including the American Board of Medical Specialties (ABMS) and the National Board of Physicians and Surgeons (NBPAS), which was developed as an alternative to ABMS.

Frederick Memorial: Lessons Learned from using an Alternative Certification Entity-- Dr. Manuel Casiano

Dr. Manuel Casiano provided the perspective of Frederick Memorial on MOC and role of NBPAS. He noted that Frederick Memorial medical staff found that there was no evidence that MOC improves quality of care, but did find evidence supporting CME as important to improving performance, and that peer review is much more effective than Board Certification/MOC as a measure of physician quality. Peer review is expensive and time consuming, but it has the best outcomes. Peer Review is the gold standard.

Issues about MOC arose about a decade ago with the American Board of Internal Medicine with concerns about the time and expense of the MOC requirements. In 2015, the medical staff changed the bylaws to allow doctors to be recertified by either ABMS or NBPAS (which does not require 10 year tests, but does require relevant CME). In the 3 years that this rule was in place, less than 1 percent of the medical staff converted to NBPAS (6/650). The doctors tend to keep ABMS for their specialty, but drop it for internal medicine. Last fall, Frederick Memorial underwent review by JAHCO, and JAHCO had no concerns. In 2017, the medical staff changed the bylaws again, so that no MOC is required. JAHCO requirements came up a lot in the hearing on the bill.

The group had a discussion about peer review, to better understand its application in all hospitals in Maryland. The Frederick Memorial peer review process was described in detail.

Dr. Casiano noted that Frederick Memorial also accepts credentials from England and the American Osteopathic Association and said discussions were ongoing about what to do about foreign credentials.

Frederick Memorial didn't consider interaction of this decision with insurers' policies, concluding the issue is up to the physicians and insurers.

Changing MOC requires a change in hospital bylaws. Most Maryland hospitals permit a change in bylaws by a majority vote of the Medical staff and an affirmative vote by the board of directors.

Overview of American Board of Medical Specialties Maintenance of Certification Requirements and Changes.—Dr. Price

Dr. Price provided an overview of the ABMS process. He noted that recertification started in the 1970s, with MOC requirements added beginning in the early 2000s, as a response to "To Err is Human". From

2012-2013, the MOC requirements were reviewed and in 2015 there was a call to the member boards to innovate to improve the relevance and reduce the costs of MOC.

There is evidence that learning combined with ongoing assessment leads to improvements. More support is coming in the literature. There is a new study in JAMA that shows that MOC is associated with better outcomes on HEDIS measures.

ABMS recognizes that MOC needs improvement. ABMS has hundreds of doctors on committees. They are increasing access to CME to increase relevance. They have a "portfolio program" in collaboration with the AHA which allows member institutions (including Hopkins) to offer alternatives to the module requirements. Under this program engagement with the organization and quality work counts. ABMS hears the concerns about expense, time, and relevance. Dr. Price agreed that the MOC program must demonstrate value, which is a function of burden, cost, and relevance. There is a need to strike a balance among these factors.

ABMS agreed that executive compensation packages are a lightning rod (available on the 990 form). ABMS feels that compensation is reasonable for executives of similar entities but has heard physicians and is working forwards Guidestar status on compensation.

MOC doesn't appear to cause physicians to leave the practice of medicine. In family medicine, there is a 5% drop out rate with or without MOC. In psychiatry and emergency medicine, knowledge increases over time with MOC but peaks and then decreases without it.

Some boards are moving to quarterly questions that you can do on your phone, which provide regular feedback. Physicians have responded positively. There is a move towards menus of activities and increased access to different CME providers, to increase relevance. Peer review programs count in portfolio program institutions.

For super specialists, there has to be a balance. "Board Certified in Cardiology" has meaning to the public and some of the content of the MOC requirements have relevance for everyone (professionalism, teamwork, etc.).

Discussion

Megan Renfrew framed the discussion with a series of questions:

1. How do you understand the problem?
2. What is your goal or desired outcome for this work?

Ben Steffen invited audience members to join work group at the table.

Several workgroup members were pleased to see changes in the ABMS MOC approach were underway. MedCHI argued that the benefits of MOC do not outweigh the costs, time, burden, and relevance issues. MedCHI continues to support initial certification. The benefit of MOC has to be "significant" enough to justify the burden. Eliminating the MOC requirement remains a MedChi goal.

Several representatives from hospitals noted that Maryland hospitals are not-for-profits directed by community boards of directors. The state should not consider legislation which would limit board discretion in establishing standards.

Educating doctors, staff, and hospital boards on this issue is difficult. Education by MHA would be helpful. The MHA representatives suggested hospitals do not support legislation that limits a local board's discretion. They further noted that ABMS brand is well known and changes proposed in MOC by ABMS are positive. Another hospital representative suggested that it would be helpful to have a clear answer from the Joint Commission.

The discussion then turned to the NBPAS that was started in 2014. Some work group members voiced support for the Board, others argued that the NBPAS did not have a proven track record.

A Johns Hopkins representative outlined their past consideration of NBPAS. The representative noted that Sibley accepted NBPAS MOC for its physicians, other Hopkins hospitals did not. These hospitals were not ready to make the change. The conversation focused on the cost to hospitals, not on the value of MOC.

The ABMS representative clarified the ABMS approach to MOC by noting that each ABMS member board has its own length of inactive status that allows a physician to get back their certification reinstated if they let their certification lapse by not maintaining MOC.

Mr. Steffen asked insurers for their input. An insurer representative emphasized the importance of credentialing and noted that insurers usually delegate credentialing to hospitals/systems. If hospitals change their process, insurers would want to know as they want to make sure that physicians are vetted. Insurers believe that a credible body should be responsible for the vetting.

CareFirst noted they do not require board certification or MOC as part of the credentialing process, so this has no impact on their credentialing of providers in their network nor on their delegated credentialing process. While possible solutions pertaining to the MOC issue raised by MedChi will not impact CareFirst directly, it does not believe that it is appropriate to impose limitations on a carrier's discretion in its credentialing process in any proposed legislation.

The League of Life and Health members took no position on the legislation. Cigna will check to see if MOC is required by for non-employed/unaffiliated doctors.

Next steps

Ms. Renfrew reviewed follow-up issues, described next steps and noted the next meeting time and date.