Physician Maintenance of Certification Work Group Meeting Summary
July 24, 3:00 PM to 5:00 PM
Maryland Health Care Commission
MHCC Offices, 4160 Patterson Avenue, Baltimore, MD

Committee Members in Attendance:

Ben Steffen, MHCC
Megan Renfrew, MHCC
Steve Wise, MedCHI
Wynee Hawk, Maryland Board of Physicians
Jen Witten, MHA
Dr. Dan Morhaim, General Assembly, NBPAS
Dr. Jeff Fernley
Rianna Matthews-Brown, Johns Hopkins, for Peter Hill
Pegeen Townsend, Medstar, Representing Keith Shiner
Kimberly Robinson, Cigna, for Dr. Christina Stasiuk
Debra Rivkin, Carefirst
Dr. Michael Nelson, ABMS
Tinna Quigley, League of Life & Health Insurers

Other Individuals in Attendance:

Lindsay Rowe, HGO/DLS
Dr. Jennifer Hollywood, Easton, unknown affiliation
Dr. Marion Mass, NBPAS
Thomas Granatir, ABMS

Welcome

Ben Steffen welcomed all to the meeting. Attendees identified themselves.

Objectives and Brief Updates

Ms. Renfrew of the Maryland Health Care Commission (MHCC) reviewed the agenda and updated attendees on the work plan. She referred the work group to documentation on proposed amendments to HB 857 (2018) and updates to the document containing selected provisions of Maryland law related to physician Board Certification related to Maryland Board of Physicians authority to approve alternative boards and the interstate compact on physician licensure.

Joint Commission: Ms. Renfrew also summarized her research into potential conflicts between state law and Joint Commission hospital accreditation standards. Joint Commission accredited entities must comply with state and federal law. If the Joint Commission found that a hospital did not meet one of their standards (for example, because of a state law that limited the hospital and medical staff's flexibility in setting credentialing requirements), and the hospital's compliance with state law was the cause of that finding, the hospital could respond to the Joint Commission finding by pointing to the state legal requirement. That justification would be acceptable to the Joint Commission for accreditation purposes.

There was also an outstanding question about why the Joint Commission included specific requirements for board certification with named boards for accreditation of ambulatory sleep centers (the Joint Commission is not a prescriptive for hospital accreditation). The Joint Commission wanted their accreditation to be accepted by insurers and a number of insurers had started to require board certification for physicians interpreting sleep studies, so the Joint Commission included the requirement in their accreditation standards. This requirement for reimbursement was likely imposed because of a

rapid increase in claims for sleep studies (including a Government Accountability Office report[1]) and fraud at some facilities. Some of insurers now require these facilities to be accredited. Board certification entities were identified through 1) outreach to national recognized experts and professional associations and organizations, 2) engagement with stakeholders identified by the entities in item #1, and 3) a public comment period. The National Board of Physicians and Surgeons (NBPAS) was not identified during this process.

Megan also presented data from the 2016 Board of Physicians Licensure files that shows that 61% of actively practicing physicians in Maryland are affiliated with a health system or hospital. This data is useful to understanding the impact of hospital and health system credentialing rules (and delegated insurer credentialing) on physicians. A work group member asked if this data could be broken down by specialty.

Presentation: National Board of Physicians and Surgeons

Dr. Marion Mass, a practicing pediatrician in Pennsylvania, presented the position of the NBPAS to the work group. The current maintenance of certification process was described as expensive, onerous, and time consuming, but the benefit is not proven. She criticized the American Boards of Medical Specialties (ABMS) and the American Osteopathic Association as high revenue, anti-competitive, regulatory monopolies over board certification. She also criticized the distinction between life time certifications and time-limited certifications at ABMS and AOA as discriminatory because a larger burden is placed on younger physicians, who are more likely to be female and/or minorities.

NBPAS is an alternative to ABMS and AOA recertification which is less expensive (approximately $75/year) and less time consuming (50 hours of continuing medical education (CME) every 2 years). NBPAS requires prior certification by ABMS or AOA and has some requirements related to hospital privileges. Thus NBPAS certification is a higher bar than state licensure, even though the hourly CME requirements are the same as MD's licensure CME requirements. The work group had a small discussion about the extent to which NBPAS validates physician supplied data.

Approximately 7,000 physicians are members of NBPAS and 77 hospitals accept the certification nationwide. NBPAS was founded in December 2014. NBPAS supports legislation that encourages competition among board recertification organizations.

The group had a discussion about concerns with maintenance of certification (MOC) requirements, ABMS's proposed path to making changes, physician work force shortages in rural areas, and the value of competition. This lead to a discussion of whether having an assessment component to recertification is important. ABMS takes the position that it is necessary to ensure learning and measure competency, while NBPAS feels that CME is enough and no testing is needed. Some work group members feel that all recertification requirements are unnecessary, given licensure CME requirements. ABMS also believes that MOC is important to transmitting ethics and professional culture (ex. Professionalism and communications components).

[1] Author's Note: this is likely intended to reference a 2013 OIG Report: Levinson, Daniel R. , Questionable Billing for Polysomnography Services, Office of the Inspector General, October 2013, https://oig.hhs.gov/oei/reports/oei-05-12-00340.pdf

Approaches to MOC Legislation in GA, OK, SC, TX, TN

Ms. Renfrew reported on her research on the five states that have passed legislation related to hospitals and/or insurers use of physician maintenance of certification information. Ms. Renfrew produced a memo that is posted on the work group website that summarizes and compares these approaches and contains the relevant statutory text. All of the statutes are less than 2 years old, with effective dates ranging from November 1, 2016 and July 1, 2018. There is very little data to understand the impact of these laws at this point, either on the number of physicians choosing to forego recertification or any ability to see if that impacts quality or physician discipline.

The bills took two approaches:

1. Bills that change the title of the state code related to professional regulations of physicians but that prohibit differentiation between physicians based on MOC for "reimbursement" or "employment" or privileges. In some states, this approach may be limited in impact due to the scope of these titles of the state code, combined with limiting language in the statutory language (for example, "Nothing in this [title] shall be construed to require"…) which limits application of the rule to the specific title of the code. (GA, OK, SC). The workgroup discussed how best to interpret the scope and effect of this language, given that we are not experts in law in these states. Ms. Renfrew pointed out that she did talk to staff in some of these states (see below).
2. Bills that amend the titles of the state code related to insurance and hospitals to prevent differentiation between physicians based on MOC, potentially improving the enforceability of the statutory provision. These bills do allow organized medical staffs to vote to change the default rule to allow use of MOC in privileging and employment decisions and contained an exception for facilities that needed to consider MOC as a requirement of accreditation (TN & TX).

Ms. Renfrew also contacted the Board of Physicians in several of the states to asked questions and talked to staff at the Texas Hospital Association about their new law. Two areas of confusion in Texas are whether hospitals can continue to use their existing bylaws or if they need to be readopted. They also had to make sure that the hospital boards voted on the bylaws to comply with Medicare conditions of participation. The accreditation language was to allow for existing rules re federal Trauma and Stoke designations, as well as state designations of NICU and Birth Centers.

A discussion began about whether insurers accepted NBPAS. Most insurers/carriers on the work group or represented by work group members do not require MOC, but credentialing is usually delegated to hospitals for affiliated providers. Information was not available for all carriers represented by work group members.

Discussion

Ben Steffen and Megan Renfrew transitioned the group to the discussion slide. MHCC has heard differences of opinion about how to balance physicians' autonomy over their own training/learning with hospital and insurer autonomy over credentialing. Hospitals and insurers prefer no statutory limitations on their authority. We've also heard different opinions about the value of ongoing assessment requirements.

There seem to be two distinct issues in the debate. Is the goal to end MOC requirements all together or is it to treat NBPAS similarly to other credentialing organization?

MHCC presented three policy possible approaches to addressing this issue:

1. Maintain Status Quo
    a. Health systems and insurers maintain current autonomy.
    b. NBPAS could be recognized by health systems or insurers through existing processes.
    c. NBPAS could apply to Board of Physicians for recognition through existing processes.
2. Policy Proposal
    a. Hospitals: TX style language-cannot require MOC unless need for accreditation or vote of Medical staff and board.
    b. Insurers: No change from status quo, since insurers don't seem to be requiring recertification in Maryland. Insurers would maintain current autonomy.
    c. No change to Title 14 on physician professional regulation re: board certification or NPBAS. NBPAS could use existing processes to seek Maryland Board of Physicians recognition.
3. Legislate Physician Autonomy
    a. Individual physicians decide on board certification and MOC. Hospitals and insurers cannot require MOC.
    b. Significant change to Title 14 on physician professional regulation re: MOC and perhaps NPBAS.

Discussion noted that there is a non-statutory path forward for change in hospital credentialing and to change existing credentialing boards. Insurance is not a big issue in Maryland. Hospitals reiterated their desire to retain ability to set qualifications as an employer and facility. Physician representatives asked for a path forward to share information about the work group's findings with hospitals, and that hospitals ask their staff if they would like another choice for MOC. MHA would like NBPAS to first apply to the Board of Physicians for recognition to help establish credibility.

Concern about the lack of evidence for MOC was raised. NBPAS is seen by some work group members as a vehicle for reduced MOC burden if eliminating MOC is not possible, with more physician control over the relevance of required material. NBPAS could be seen as a compromise path if eliminating MOC is not possible, although some work group members would prefer to eliminate MOC altogether. There was debate about whether a NBPAS's CME requirement, which matches the state licensure requirements was rigorous enough. Work group members debated the relative importance of MOC for addressing knowledge decay and changes in science over time.

Additional concerns raised about some approaches include the impact on surrounding states (if any), consumer's understanding of the different credentialing organizations, and potential liability issues for hospitals (the liability situation for hospitals in Maryland than in Pennsylvania).

There was also a question raised about whether an additional discussion meeting would be helpful.

Next Steps

At the end of the meeting, Ms. Renfrew expressed that she would consider the question of adding an additional meeting, but that she planned to write a draft of the report and share it with the group. The

next meeting is 9/11. The report will be brought to the MHCC meeting in either September or October [Author update: the report will go to the October 16th MHCC meeting]