

Draft Meeting Summary
Physician Maintenance of Certification Work Group
Maryland Health Care Commission
Meeting of July 10, 4:00 PM to 6:00 PM
MHCC Offices, 4160 Patterson Avenue, Baltimore, MD

Committee Members in Attendance:

Ben Steffen	Deb Rivkin
Megan Renfrew	Tinna Quigley
Rich Tabuteau (for Steve Wise)	Dr. Christina Stasiuk
Erin Dorrien	Dr. Michael Nelson
Katie Wunderlich	
Dr. Dan Morhaim	

Other Individuals in Attendance:

Dr. Jef Fernley	Charles Sheffield
Rianna Matthews-Brown (for Dr. Peter Hill)	Lindsay Rowe
Pegeen Townsend (for Dr. Keith Shiner)	Dr. Marion Mass

Welcome and Introductions

Megan Renfrew started meeting. Ben Steffen welcomed all participants. All audience members were invited to sit at the table.

Administrative Updates and Meeting Objective

Megan Renfrew, MHCC, welcomed Dr. Nelson to the workgroup. Dr. Nelson is representing the American Board of Medical Specialties.

The 2 remaining scheduled meetings will run from 3-5pm.

This meeting will focus on bill amendments, discussion of principals, and areas where remaining clarification and discussion is needed. Megan reminded the group that the work plan allows for 1 more meeting for discussion and then a final meeting in September.

Legal Context- Revised

Bill Amendments: Megan Renfrew noted that bill language reviewed in the first meeting of the workgroup was the introduced version of the bill. MedChi had drafted and circulated amendments before the bill hearing in the House Health and Government Operations Committee. Megan described

what these amendments would have done to the bill language and impact: preventing carriers from requiring MOC or using MOC in rate setting; preventing hospitals from requiring MOC as a condition of credentialing or privileges; and amending the existing definition of “Board Certified” in title 14 of Health Occupations to add NBPAS and allow initial certification to count.

Existing Statutory Provisions: Megan also shared a document which contains current provisions of Maryland law related to board certification. The workgroup discussed a number of issue related to this information, including how the provisions of law relate and the impact of the proposed amendments.

Other States: The group reviewed and discussed an AMA fact sheet showing that 5 states have passed statutes related to MOC that impact hospitals and/or insurers. The group asked for more detail on these bills and information about the experience in these states with respect to safety and quality. The ability to learn from these states may be limited since these bills were recent, but Megan committed to try to find information.

Follow-up items

Dr. Stastiuk stated that Cigna does not require MOC when credentialing health providers who are unaffiliated with a health system. Most credentialing is delegated to hospital systems.

Ms. Quigley will provide an update on the position of the League of Life and Health at the next meeting.

Megan Renfrew provided an overview of information provided by the Joint Commission though the Medical Staff chapter of the Comprehensive Accreditation Manual for Hospitals. The Joint Commission values autonomy in the hospital’s medical staff governance process. Thus, the Hospital board and the medical staff itself define membership criteria. The Joint Commission does not require members of the medical staff to be board certified. ABMS is mentioned in reference to the 6 general competencies developed with ACGME, but is not required.

This differs from the Joint Commission’s approach to ambulatory sleep centers, which requires certification by named boards(“e American Board of Sleep Medicine (ABSM) or by a member board of either the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA)”. NBPAS is not a named board.

The group discussed the Joint Commission’s approach. Key questions included: Why was this new rule for ambulatory sleep centers needed? Was NBPAS considered and rejected, or just not considered? The group discussed the challenge in quality in this sector.

It does appear that the Joint Commission has not decertified any hospital for choosing not to consider MOC or allowing for an alternative board.

Principles

The workgroup discussed possible principles, in an attempt to establish both areas of agreement and areas of continuing disagreement. MHCC provided 5 draft principles for reaction.

Original Draft principles

1. The work group agrees that reducing administrative **burden** on physicians is important.
2. The work group agrees that supporting high quality **patient** care is important.

3. Periodic, meaningful, relevant **learning** and evaluation is important for physicians.
4. **Competition and innovation** among organizations that provide maintenance of certification services can be useful in improving customer service, increasing responsiveness and lowering costs.
5. Organizations that provide maintenance of certification services should offer robust and **transparent** programs that are linked to improved patient care and support providers in delivering improved patient outcomes.

Burden

Workgroup members agreed that burden is an issue. ABMS has had an ongoing commission on MOC, which is looking at the variation in burden across boards. Historically the burden has been large. This commission will report to the ABMS board in February 2019 with a plan. The group includes practicing physicians and conducted a formal survey of physicians to gain feedback. It is independent. The cost is passed on to consumers and insurers.

To some members of the group, this felt like too little, too late, particularly with no commitment to reduce cost. A concern was also raised about access to physicians, since time spent in training & certification activities is time that is not scheduled with patients, and also time away from family.

This principle was well supported by the group.

Proposed revised principal: The work group agrees that reducing administrative burden and costs on physicians and institutions is important.

Patients

This should be the most important principle—move to #1. Also, change “supporting” to “providing”. This principle was well supported by the group.

Proposed revised principal: The work group agrees that providing high quality patient care is important.

Continuous Learning

Within the text, the group suggested replacing “periodic” with “Continuous”. The meaning of the word “meaningful” was discussed in the context of the evidence on CME effectiveness vs. MOC effectiveness. “Relevant” was considered an important factor. The word “evaluation” also was discussed—it means “testing” it is unfair to those who don’t test well—is it intended to mean written performance (not that relevant to practice) or longitudinal assessment?. If it means the hospital medical staff evaluation processes, that is fine, and constant. There were mixed feelings in the group about whether doctors, as a whole, were highly motivated to keep up on current information or if some evaluation was necessary to confirm/incentivize learning. One workgroup member suggested “ongoing relevant educational activities are important.” While the group agrees that ongoing learning is necessary for physicians, disagreement about the inclusion of assessment and evaluation prevented agreement on this principal.

Proposed revised principle: Continuous, meaningful, relevant learning and assessment is important for physicians.

Competition and innovation

There was a discussion of what the purpose of this principle was and whether it was useful to the project of the workgroup. We all should agree with professional self-regulation, and customer service and responsiveness are key. The focus on this principle was intended to be the power of alternatives to bring change. But, the alternatives have to be rigorous. Flexibility is also important—different practices and different doctors have different needs for learning. Patients should be able to rely on “board certified” as having meaning, being credible.

There was discussion of what “credible” means in this context: NBPAS is still building credibility (similar to how URAQ built credibility when it first started), but both organizations have credible arguments for their points of view.

There was discussion about whether this principle reflected a shared point of view. For some work group members, the primary goals are quality care and knowing what the credentials signify. Competition is secondary.

*Proposed revised principal: **Competition and innovation** among credible organizations that provide Board certification standards and Maintenance of Certification services can be useful in improving customer service, increasing responsiveness and lowering costs.*

Transparency

There was discussion about whether programs should be evidence-based or if that requirement would limit innovation/streamlining (because the new processes would not be proven). Perhaps a commitment to evaluate new processes and programs would be better.

Patients are the stakeholders—we need to be sure we reflect their importance.

There was concern about tying a principle to outcomes, which the physician cannot fully control.

Proposed revised principal: Organizations that provide maintenance of certification services should offer robust and transparent [evidence-based] programs that are linked to improved patient care and support physicians in delivering informed quality care.

Complete list of revised principles

1. *The work group agrees that providing high quality patient care is important.*
2. *The work group agrees that reducing administrative burden and costs on physicians and institutions is important.*
3. *[No agreement] Continuous, meaningful, relevant learning and assessment is important for physicians.*
4. *[No agreement] Proposed revised principal: **Competition and innovation** among credible organizations that provide Board certification standards and Maintenance of Certification services can be useful in improving customer service, increasing responsiveness and lowering costs.*
5. *[Staff recommended change, not clear if agreement was reached] Organizations that provide maintenance of certification services should offer robust and transparent [evidence-based] programs that are linked to improved patient care and support physicians in delivering informed quality care.*

Discussion

The work group discussed areas where agreement has not been reached. Hospitals currently have responsibility and authority for credentialing physicians, and hospitals want to maintain autonomy. Would legislation that only impacts board certification affect accreditation?

Given the earlier discussion, it seems that there are not accreditation or insurance issues, so this could be solved without legislation. Hospitals could look at NBPAS, as some already have, and consider if changing medical staff credentialing/privileging makes sense.

There are 78 hospitals that use NBPAS nationwide, and Atlantic General will be considering NBPAS at the next Board meeting (it has already been approved by the bylaws committee and the executive committee).

Credentialing of unaffiliated doctors for insurance was discussed. Insurers use CAQH, a uniform credentialing designated entity. Several members noted that CAQH serves as a repository for information needed for credentialing but does not itself credential providers.

Hospitals want to put quality of care first, but also philosophically do not want to have their autonomy limited by legislation. Physicians want to define their own standards without having hands tied. This is the fundamental conflict on this issue.

Hospitals also perceive a potential medical liability issue that is bigger for them than for physicians.

Next steps

Task	Responsible Party
Update List of statutory provisions with section 14-101.1.	Megan Renfrew
Review June meeting notes and suggest edits. Due 7/17/2018	Work group members
Find information about the 5 states with bills that passed re: hospitals/carriers -bill text -implementation stage -experience (take-up rate, quality, discipline, safety, experience of hospitals and insurers)	Megan Renfrew
Follow-up with Joint Commission on Questions: 1. Why was the ambulatory sleep center rule required? 2. Was NBPAS considered? 3. If state law restricted hospital autonomy on acceptable boards and/or consideration of MOC, would that be a problem for JC accreditation?	Megan Renfrew
# of NBPAS members nationally and in 5 states that passed hospital/insurer bills.	Dr. Marion Mass
Talk to Wynee re: letter and statutory impact	Megan Renfrew
How many doctors in Maryland are unaffiliated? Of that number, how many are practicing?	MHCC