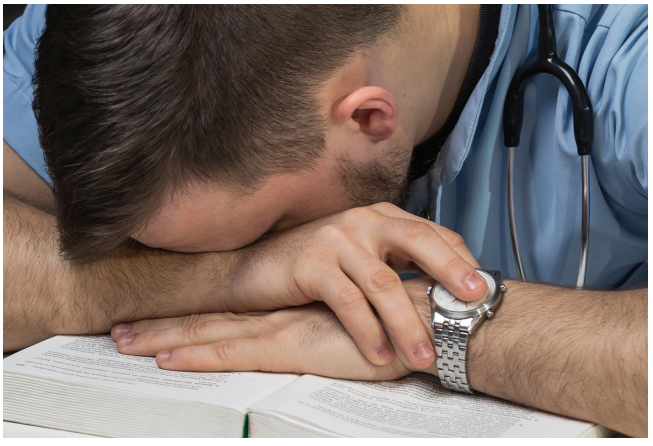
Maintenance of Certification

Do we have a certified crisis in medicine?

BY PAUL G. MATHEW, MD, DNBPAS, FAAN, FAHS

Since inception in 2007, the American Board of Medical Specialties (ABMS)/American Board of Psychiatry and Neurology (ABPN) maintenance of certification (MOC) programs have been under heavy scrutiny by practicing physicians. Those who were board certified before 1994 are considered "grandfathered" and are not required to participate in the programs, which is not only a form of ageism, but also discriminatory against female and minority physicians, who make up a higher proportion of nongrandfathered physicians. The MOC programs are expensive, time consuming, unproven, and of questionable relevance to current practice.



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COSTS AND REVENUES

Taking into account the cost of the exam, preparation materials, travel, and time away from practice, physicians who are certified in a single specialty can spend more than $16,000 per 10-year certification cycle. Those who are certified in multiple specialties may spend more than $40,000 to comply with MOC.[1] In addition to losing revenue from physicians not being able to see patients when they take time off for MOC activities, institutions are also reimbursing physicians for MOC-related expenses. This is money better spent addressing the opioid crisis and other patient-centered programs. In 2013, ABMS-member board revenues were $263 million, and expenses totaled $239 million, resulting in a $24 million surplus. Examination fees accounted for 87.7 percent of revenue. Officer and employee compensation and benefits were 42.2 percent of expenses.[2]

LACK OF EVIDENCE

The unproven nature of MOC is quite striking. Much of the literature cited by the ABMS is in support of initial board certification rather than MOC. Many of the cited articles are authored by ABMS employees, some of whom are paid nearly $400,000 in salary—clearly a financial conflict of interest.[3,4] To better demonstrate the lack of evidence supporting MOC, two independent reviewers formally reviewed the major studies of MOC cited by the ABMS. From the ABMS member boards' marketing materials, 10 studies were selected for review because they appeared to have the most robust data. To quote one of the reviewers, "I was struck by the limitations of the evidence base specifically regarding the current implementation of MOC. Several of the studies are descriptive only, and even these illustrate the difficulties in execution of some of the MOC content (eg, performance improvement modules). Some of the studies do not draw meaningful distinctions between initial certification and subsequent MOC. Additionally, the issue of "grandfathering" (something directly counterintuitive to the concept of ongoing MOC) is not adequately addressed in the published literature."[5]

In terms of the content, MOC is not tailored to an individual learner's interests or educational needs. In the case of neurology, a blatant example of irrelevant material is testing of microscopic pathology slides. This exercise in brute memorization has no real relevance to practice, because interpretation of slides is not a component of neurology practice. Yet, it is tested, and our residents spend countless hours memorizing slides to prepare for exams. Although understanding underlying pathophysiology is important, slide identification is not. This would be like expecting neurologists to be familiar with the nuances of a particular neurosurgical procedure. Although it may be important to know when a certain neurosurgical procedure is indicated, the details of how to perform it are not within the scope of learning for a neurologist. In addition, the ABMS has claimed for years that participation in MOC keeps physicians

up to date with cutting-edge material. This is not the case, as MOC material in any medical specialty must be generally considered the standard of care and/or guideline based, and it can take years for new concepts to reach such acceptance. Cutting-edge material is learned by completing CME activities, reading journal articles, reviewing online resources, and discussing cases with colleagues—not via MOC.

COMPETITION IN RECERTIFICATION

Although MOC compliance is not required to secure a medical license, it is a requirement for credentialling by many insurance carriers. As such, hospitals similarly require their physicians to be MOC compliant. Many state and specialty societies sell the modules required for MOC compliance giving them a financial interest in keeping MOC as the status quo requirement to practice medicine. In my field, the MOC programs of the ABPN are further bolstered by the United Council of Neurologic Subspecialties (UCNS), which certifies physicians in neurologic subspecialties not offered by the ABPN. In order to sit for a UCNS initial certification examination, a physician must be board certified by the ABMS/ABPN. In order to sit for a UCNS 10-year recertification examination, a physician must be MOC compliant. This practice has led some physicians not to recertify with UCNS, as they refuse to comply with the requisite of ABPN MOC compliance.

As dissatisfaction with MOC has risen, editorials were written and petitions were generated gathering the signatures of thousands of physicians.[6] Despite the mounting criticisms and calls for reform from diplomates, specialty societies, and state medical societies, the ABMS and its 24 member boards remained committed to MOC. This unwillingness to make reasonable concessions led to formation of the National Board of Physicians and Surgeons (NBPAS.org), an organization that recertifies physicians in any specialty. The cost for two-year recertification is $169, and the requirements include:

1. Prior certification by an ABMS member board
2. Valid unrestricted medical license
3. At least 50 hours of ACCME-accredited CME within the past 24 months (physicians-in-training are exempt)
4. For selected specialties, active hospital privileges in that specialty
5. Clinical privileges in certified specialty have not been revoked permanently.

LEGISLATION

Because the majority of hospitals, insurance companies, specialty societies, and state medical societies had little interest in seeking ABMS MOC reform or accepting NBPAS recertification as an equivalent alterative, legislative solutions were sought. Oklahoma was the first state to pass an effective MOC bill, which limited the use of MOC as a requirement for practice and credentialing. This was subsequently followed by similar bills being passed in Texas, Georgia, and Tennessee. There are numerous bills all over the country, which, if passed, will lead to more states giving physicians the option to recertify with NBPAS rather than compulsory participation in MOC. This is unfortunately an uphill battle, considering the lobbying efforts of the ABMS that I have witnessed while testifying at multiple state legislature hearings that are made to crush any procompetition legislation proposed. The irony of course is that the ABMS purports that it believes MOC compliance should be a voluntary process, yet it is fighting legislation to ensure that it remains voluntary. Below is a line of sample legislation that I drafted, which has been adopted in some bills.

"Active certification in a given medical specialty can be used as criteria for physician reimbursement, employment, hospital staff/admitting privileges, licensure, and malpractice coverage in (insert state), but requiring a particular certifying organization is prohibited. For the purposes of this document, active certification shall mean a continuing education program in the practice of medicine or surgery that is approved by the ABMS and its affiliated boards, the NBPAS, or an equivalent board recognized by a hospital/institution's governing body."

This language will give hospitals flexibility to accept credentials from other certifying bodies. For example, let's imagine that a world expert in cardiac valve replacement from France wishes to practice at a hospital in the US, and she or he has secured a US medical license. The hospital could then choose to recognize that physician's board certification from France in cardiac valve replacement as an acceptable credential. This is certainly more reasonable than making that expert take US board exams in a specialty where she or he is clearly an expert.

In addition to activity on the state level, the ABMS monopoly in board recertification has attracted the attention of the federal government. On September 10, 2018, the Department of Justice (DOJ) issued an opinion letter regarding MOC. The letter applauded state legislatures for considering this issue. It also noted that MOC may harm competition, increase the cost of health care services to customers, and impose overly burdensome conditions on physicians who wish to maintain their certification.[7]

INTERNAL REFORM EFFORTS AND THE VISIONS COMMISSION

In response to the growing sentiment against MOC, some of the ABMS boards including the ABPN have started alternative pilot programs to the traditional 10-year high stakes recertification examination. Instead, diplomates would be required to take online quizzes after reading journal articles that are preselected by the board. The issues with these

pilot programs include the same problems that plagued the 10-year recertification examination. These preselected articles may not fit the interest or the educational needs of the individual learner. The cost remains excessive considering that journal articles are not always included with the cost of the program (ie, learners must secure their own articles from the list of required articles), there is a lack of evidence for value or improvement of patient care, revenues generated by the ABMS greatly exceed expenses, and the bulk of ABMS expenses foreseeably continues to consist of bloated salaries.

With the continued groundswell of MOC criticism, the ABMS formed a 27-member independent commission called the Continuing Board Certification: Vision for the Future Commission. The Vision Commission was composed of diverse stakeholders including practicing physicians, healthcare leadership, academic medicine, group medical practices, state/national medical associations, ABMS Board Executives, specialty societies, and health care advocacy groups. After hearing 21 hours of testimony, including live testimony from me, the Vision Commission released a draft report on December 11, 2018. The report clearly details how MOC has harmed physicians, but there is a lack of immediately actionable recommendations for change. After the report released, there was an opportunity for public comment.[8] More than 20,000 physicians electronically signed a response generated by the NBPAS that made the following four recommendations:

1. An immediate end to requiring secure, high-stakes examination components of MOC
2. An immediate end to requiring quality initiative (QI)/practice improvement (PI) components of MOC
3. Retention of the CME and professionalism (eg, licensure) components of MOC only
4. A reduction in fees charged for MOC, preferably, to under $100/year, regardless of the number of certifications maintained.[9]

LITIGATION: CLASS ACTION LAWSUIT FILED

In a recent development, a class action lawsuit was recently filed in Federal Court in the Eastern District of Pennsylvania. On behalf of more than 100,000 internal medicine physicians, the suit was filed by 4 internists against the American Board of Internal Medicine (ABIM), the largest of the ABMS member boards. The suit alleges that the ABIM illegally ties its initial board certification to MOC, which forces physicians to pay in order to keep their certification. The suit also alleges that required MOC compliance in its current form prevents reasonable competition in the medical marketplace.[10]

SUMMARY

Between the growing number of states adopting laws to protect physicians from forced MOC compliance, the increasing number of hospitals/institutions accepting NBPAS as an alternative to ABMS recertification for physician credentialing purposes, and the potential ramifications of a decision in favor of the plaintiffs (practicing physicians) in the ongoing class action lawsuit against the ABIM, practicing physicians everywhere may at some point in the near future witness meaningful reform or possibly an end to forced MOC compliance. Until then, becoming a diplomate of NBPAS (being dual boarded if your ABPN certification has yet to expire), and adding the suffix DNBPAS (Diplomate of the National Board of Physicians and Surgeons) after your MD or DO is a way to help increase the acceptance and leverage of NBPAS. Other proactive options include petitioning your local hospital's credentialing committee to join the growing number of institutions that accept NBPAS as an alternative to MOC compliance, as well as reaching out to medical society leadership and legislators about supporting procompetition policies. Resources are available on NBPAS.org. No matter the specialty, these actions will help end forced MOC compliance, reduce physician burnout, and improve patient access to health care while reducing costs. ■

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