Maintenance of Certification (MOC) has recently become a cause célèbre throughout the entire practice of medicine. Of course, MOC is just one of several burdens of dubious value in the name of “quality” with which physicians are saddled. Physicians must also satisfy the demands of interested parties, including Medicare, private insurance companies, and various consumer and patient advocacy groups. Meanwhile, we must also satisfy measures for Physician Quality Reporting System (PQRS) and ICD-10, which are codified within Medicare law and the Patient Protection and Affordability Act (PPACA). MOC, if not the most onerous of the demands, is at least the most immediate one, and offers the best opportunity for alternative means of compliance.

The American Board of Medical Specialties (ABMS) is made up of 24 member boards. The mission of the ABMS is to serve the public interest and promote excellence in the practice of medicine. Physicians who completed board certification prior to October 1, 1994 were granted lifetime certificates. For Diplomates seeking initial board certification after this date, time-limited certificates were issued, and the ABMS mandated re-certification for these diplomates. As such, after 10 years, physicians were required to take a re-certification examination in addition to meeting the usual CME requirements to maintain an active medical license. In 2007, the ABMS mandated that the recertification programs of its subsidiary boards transition to what today is referred to as Maintenance of Certification programs. In addition to the 50–100 hours of CME required every two years (by most states) and a recertification written examination every 10 years at a cost of more than $1,500 to physicians, the ABMS added other requirements for MOC, including the so-called Self Assessment (SA) modules and Improvement in Medical Practice (PIP) modules.

According to the ABMS website, “the change from recertification to MOC strengthened the program and guaranteed that physicians were current in ways not immediately available for testing.” At the same time, the ABMS determined that these standards should not apply to Diplomates who had completed board certification prior to October 1, 1994, thereby holding “grandfathered physicians” to a lower standard than the rest of their peers, notwithstanding that many of the older physicians—who are many years out of their residency training—may be among the ones who are least up to date with current practice.

MOC is at best a dubious concept with unclear goals. What the public and physicians alike want to ensure is that all professionals charged with maintaining and protecting the health of patients are competent in what they do. The initial board certification process traditionally has been an attempt to do just that—to show that a board candidate can demonstrate a basic competency as a physician in his or her chosen field. On the other hand, the current ABMS MOC requirements do not and cannot assure that a practicing physician has maintained his or her competency to practice medicine. The ABMS acknowledges this concept. In fact, one ABMS member website has included the following statement: “Many qualities are necessary to be a competent physician, and many of these qualities cannot be quantified or measured. Thus, certification is not a guarantee of the competence of the physician specialist.” In other words, board certification is meant to demonstrate
CRITICISM, CONTROVERSY, AND PUBLIC PERCEPTION

Over the last year, much criticism has been directed against MOC and there is some evidence that the issue begun to take hold publicly. For example, in a recent overview of the MOC issue published in the New England Journal of Medicine (January 8, 2016), Dr. Paul Teirstein, Chief of Cardiology at the Scripps Clinic, criticized the financial aspects of MOC as they apply to both individual physicians and the ABMS and its subsidiary Boards, in this case the American Board of Internal Medicine (ABIM). Shortly after this article appeared, the ABIM issued a “mea culpa” and suspended some of the Practice Assessment, Patient Voice and Patient Safety requirements for at least two years. MOC has breached the lay media, as well. Newsweek’s Kurt Eichenwald has written multiple pieces on MOC, covering problems with board certification, as well the exuberant salaries, bonuses, and luxurious perks that the ABMS has been awarding itself at the expense of its Diplomates. And yet, in response to these reports, the ABIM accused Mr. Eichenwald of being biased because he is married to a physician.

While the public perceives correctly that there are major problems with medicine and our health care delivery system, often misidentified are both the causes and the solutions. Ironically, the proposed solution to add more unnecessary administrative and regulatory requirements to an already labyrinthine system actually compounds rather than mitigates the problems.

We all know that most medical errors and complications have little to do with individual providers being out of date, per se, other than in the case of impairment due to age and illness, which is a separate problem entirely and must be addressed directly. Much is the result of the lack of a systematic and rigorous approach to the provision of care along the lines of what Atul Gawande and others have been writing about for years. When physicians are encouraged—even forced—by the system to spend no more than 15-20 minutes with a patient, much of which already consists of checking off senseless bullet points on an EHR screen, all the up-to-date knowledge in the world is not going to help them provide better care. Patient advocacy groups and politicians do not appear to understand this concept, however.

The other unfortunate irony is that re-licensure and recertification burdens will not likely weed out the bad actors, but may rather serve to annoy and frustrate the good ones. The challenge is to educate the public and the patient advocacy groups as to what should be done to reduce the inadequacies they perceive in the system (some of which are very real), rather than to accede to their own poorly conceived remedies for problems they do not really understand. To charge them with making medical policy is like having a

MOC Requirements

Ahead is a brief summary of current MOC requirements. The details are readily available at http://www.abpn.com/wp-content/uploads/2015/03/MOC_web_doc.pdf

1. Professionalism and Professional Standing

2. Lifelong Learning (CME) and Self-Assessment (Beginning January 1, 2014, diplomates are required to use only ABPN-approved products for self-assessment activities, which are found on the ABPN website (www.abpn.com). The ABPN will approve additional programs over time and reserves the right to approve or reject any course or guideline submitted for approval.)

3. Assessment of Knowledge, Judgment, and Skills

4. Improvement in Medical Practice (PIP), which consists of a Clinical Module (initial chart review and 2 year reassessment of at least five patients, assessing the charts for adherence to best practices, practice guidelines, peer standards, and then developing and carrying out a plan to improve clinical effectiveness and/or efficiency), and a Feedback Module (from which the Diplomate can choose ONE, including peer feedback from five peers, resident evaluation from five respondents, 360 degree evaluation from five respondents, institutional peer review from five respondents, and supervisor evaluation from one supervisor.)

competence, but the board does not want to guarantee competence. This concept also nullifies the notion that the American College of Physicians (ACP) raised, that if you become involved in litigation, Board certification will somehow protect you. The fact is that if you are negligent, no piece of paper hanging on your wall will protect you.

The ABMS requirements for MOC (as reviewed in the sidebar above) are arbitrary and untested. The costs to practicing physicians both in terms of time and money to complete this process are considerable. In a recent study, physician compliance with MOC was found to cost anywhere from $23,607 to $40,495 over a 10-year period depending on specialty. Yet, there is no published evidence to show that any of these requirements except for Continuing Medical Education (CME) serve to improve quality of practice on an individual basis. No one would argue that CME is irrelevant, and most states require CME (25-50 hours of accredited CME per year) for maintenance of licensure.
“Unfortunately for the ABMS boards, more physicians are starting to understand that there is now another pathway to re-certification. Over 3,000 physicians have become diplomates of NBPAS, which has become accepted as a viable alternative to ABMS by an increasing number of hospital credentialing departments.”

A NEW PATHWAY
Fortunately, there is a viable alternative to the ABMS pathway to MOC. The National Board of Physicians and Surgeons (NBPAS), which was started by Dr. Paul Teirstein, is offering recertification in selected medical specialties. The Board of Directors of the NBPAS comprises members representing many of the country’s top clinics, academic institutions, and specialty organizations (see Figure 1). All physician members and directors of the NBPAS are volunteers (there is a small paid administrative staff, of course), in contradistinction to the ABMS and its member Boards, in which the members of these Boards are paid in six figure dollar amounts annually. (http://990s.foundationcenter.org/990_pdf_archive/410/410654864/410654864_201212_990O.pdf)

The NBPAS has established the following criteria (NBPAS.org) for its recertification:
1. Previous certification by an ABMS member Board
2. Valid license to practice medicine
3. At least 50 hours of ACCME accredited CME within the past 24 months (physicians-in-training are exempt)
4. Active hospital privileges (for select specialties)
5. Clinical privileges in certified specialty have not been permanently revoked
6. Cost: $169 for a two-year certification, not including the cost of obtaining CME credits

The MOC requirement itself is incorporated in Medicare law and under the PPACA, although there is ambiguity regarding whether MOC must be obtained via the ABMS Specialty Boards. When these laws were written, the ABMS was essentially “the only game in town” for physicians. The ABMS has been challenged in terms of being a monopoly organization for specialty certification and recertification. Presumably because of this, or perhaps as a pre-emptive defense, the ABMS has recently acknowledged publicly that it does have competition in the form of the NBPAS. To punctuate this point, one ABMS member website has included the following statement, “Possession of a Board certificate does not indicate total qualification for practice privileges, nor does it imply exclusion of other physicians not so certified.”

Due to pressure NBPAS and others the ABMS boards have had to reconsider their position on MOC. Beginning in 2016, the American Board of Anesthesiology decided to discontinue their 10-year recertification examination. Instead, their diplomates will be taking an online 30-question quiz per calendar quarter (120 questions per year). Many of the previous requirements remain in place. Although this is a step in the right direction, one must assume that making a 120 question, online, open-book exam for all diplomates recertifying is significantly cheaper to produce and administer than a secured 10-year exam. That being said, the cost of this new MOC program is $210 per year instead of a lump sum $2,100 to take the closed book exam every 10 years. Clearly, the boards feel a reduction in cost of production to the boards should not translate to a reduction in cost to the diplomates, and that the boards should actually generate even greater revenues.

THE FUTURE OF BOARD CERTIFICATION
Despite the mild progress we have seen, I have voiced my concerns to ABMS leadership.

Meaningful MOC reform should include all of the following:
1. Removing the 10 year recertification exam
2. Lowering the cost of MOC if a quarterly online question format is put in place. Keeping the same fee structure would be ridiculous considering the expense to the ABMS is much smaller for this than generating and administering a 10-year exam. Participants should receive CME credit for completing these online modules.
3. Removing unnecessary, cumbersome, and unproven modules (PIP & SAE)
4. Basing re-certification primarily on CME and a clean practice record

The ABMS boards acknowledge that the National Board of Physicians and Surgeons (NBPAS) exists as a legitimate alternative board, but they do not feel threatened at all. They are very confident that physicians, like sheep to be herded, will continue to blindly pay to do unnecessary work in the name of board certification.
ARE YOU FRUSTRATED BY MOC? LOOKING FOR AN ALTERNATIVE?

Certify at NBPAS.org

Many ABMS member boards have created Maintenance of Certification (MOC) requirements which require significant time and expense and have no proven value. For many physicians, participation in MOC activities is required to maintain board certification and board certification is required to maintain hospital privileges.

A new certifying organization, the National Board of Physicians and Surgeons (NBPAS.org), was created to provide an alternative to ABMS certification. NBPAS certification requires initial certification by an ABMS member board but uses accredited CME instead of MOC as the primary measure of continuing certification. Accredited CME is a meaningful educational activity that can be tailored to an individual physician’s practice.

After only one year of operation, over 3100 physicians are now NBPAS certified.

Many hospitals now accept NBPAS as an alternative to ABMS certification.

Summary criteria for NBPAS certification:
- Previous certification by an ABMS member board
- Valid license to practice medicine
- At least 50 hours of ACCME accredited CME within the past 24 months
- For selected specialties, active hospital privileges in that specialty
- Clinical privileges in certified specialty have not been permanently revoked

NBPAS is a Not For Profit 501(c)(3) corporation.

Physician leaders and board members are not paid.

Two things you can do to help this grass roots movement:
1) Go to NBPAS.org to learn more and apply for NBPAS certification. The application is painless, user friendly and takes <15min. The cost is $169 for two year certification.
2) Petition your hospital’s credentials and medical executive committees to accept NBPAS as an alternative to ABMS certification.

Download sample PowerPoints, petitions, and letters to spread the word at: NBPAS.org

NBPAS Board Members:
Paul Teirstein, M.D., President NBPAS, Chief of Cardiology, Scripps Clinic
John Anderson, M.D., Past President, Medicine and Science, American Diabetes Association, Frist Clinic, Nashville, TN
David John Driscoll, M.D., Professor of Pediatrics, Mayo Clinic College of Medicine
Daniel Einhorn, M.D., Past President, American College of Endocrinology; Past President, American Association of Clinical Endocrinologists
Bernard Gersh, M.D., Professor of Medicine, Mayo Clinic College of Medicine
C. Michael Gibson, M.D., Professor of Medicine, Harvard Medical School
Paul G. Mathew, M.D., FAHS, Director of CME, Brigham & Women’s Hospital/Harvard Medical School, Dept Neurology
Jordan Metcalf, M.D., Professor and Research Director, Pulm. & Crit. Care, Oklahoma University Health Sciences Center
J. Marc Pippas, M.D., Professor of Medicine, Dartmouth Medical School
Jeffrey Popma, M.D., Professor of Medicine, Harvard Medical School
Harry E. Sarles Jr., M.D., FACG, Immediate Past President for the American College of Gastroenterology
Hei Scherz, M.D., Chief of Urology-Scottish Rite Children’s Hospital, Assoc Clinical Professor of Urology Emory University
Karen S. Sibert, M.D., Associate Professor of Anesthesiology, Cedars-Sinai Medical Center, Secretary, California Society of Anesthesiologists
Gregg W. Stone, M.D., Professor of Medicine, Columbia University College of Physicians and Surgeons
Eric Topol, M.D., Chief Academic Officer, Scripps Health; Director, Scripps Translational Science Institute
Bonnie Weiner, M.D., Professor of Medicine, University of Massachusetts Medical School
Matthew Williams, M.D., Chief, Division of Adult Cardiac Surgery, New York University Medical Center

FIGURE 1. An ad by the National Board of Physicians and Surgeons (NBPAS.org) appearing in The New England Journal of Medicine.
Unfortunately for the ABMS boards, more physicians are starting to understand that there is now another pathway to re-certification. Over 3,000 physicians have become diplomates of NBPAS, which has become accepted as a viable alternative to ABMS by an increasing number of hospital credentialing departments. It is only through an expanding number of diplomates that NBAPS can increase its acceptance and rival the inflexible, self-centered monopoly that ABMS has become. In order to attract more diplomates, a full-page advertisement (Figure 1) will be featured in the New England Journal of Medicine in four editions.

Over time, the NBPAS should grow in terms of certificates granted. Moreover, the number of hospital credentialing committees that accept NBPAS as a viable alternative for maintenance of board certification will likely increase, as well. With more institutions accepting NBPAS certification, the influence and leverage of the NBPAS will grow, and physicians will be relieved of the burden of complying with costly and time-consuming requirements that do not improve practice. It might even force the ABMS to revise its own requirements for MOC. Ultimately, it is up to the individual physician to decide whether it is to his or her advantage to take a stand on MOC, based upon principle. There is no harm in being dual-boarded, and becoming a diplomate of NBPAS prior to the expiration of an ABMS board certification is a low risk decision that supports a pro-physician grassroots movement. During this time of unprecedented physician unity, organizations like NBPAS appear well positioned to help return the practice of medicine to physicians rather than detached administrators.

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