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MOC-limiting laws spreading to additional states

Legislatures are limiting the power of maintaining certification when it comes to licensing, hospital privileges and more

by **ED FINKEL** *Contributing author*

HIGHLIGHTS

- **In Texas, a state where about two-thirds of physicians are in either sole proprietorships or two-doctor offices, many physicians believe that MOC has grown "out of touch with the practice of medicine."**
- **In Georgia, MOC can't be used for state licensure, payer panel eligibility or public hospital priveleges, but private hospitals are exempt.**

At least 21 states now have passed or considered bills to protect physicians who choose not to fulfill American Board of Medical Specialties requirements for Maintenance of Certification (MOC) from losing their hospital privileges, insurance eligibility and/or state licensure. As of press date, three states had passed bills this year addressing the requirement to maintain certification for a variety of purposes, in addition to the five that did so in 2016.

Georgia lawmakers passed a bill in May that prohibits MOC from being used for state licensure, eligibility for health insurance panels, eligibility for malpractice insurance and staff privileges at state-owned hospitals. Texas lawmakers passed a bill that was awaiting the governor's signature at press time, which addresses licensure and insurance plans, as well as staff privileges at hospitals that are not either academic medical or designated cancer centers. And Tennessee lawmakers passed a bill in May that addresses licensure.

This legislative success pleases Paul Teirstein, MD, president of the National Board of Physicians and Surgeons (NBPAS). Founded as an alternative to the ABMS maintenance of certification process, the group has been monitoring the progress of 19 bills across the nation including the three that passed this spring.

"I am very optimistic about the bills currently pending," he said in an e-mail. "Hopefully, passage of this legislation in many states will inspire other states to create similar legislation. It is inspiring to see so many physicians support this new legislation."

NBPAS formed in 2014 in opposition to MOC programs that some physicians had begun to view as too costly and not useful or relevant to their practices. Teirstein, chief of cardiology at Scripps Clinic in San Diego, asserts MOC has become "onerous, expensive and has no impact on medical care."

Board certification gives patients the comfort level that their physician is up-to-date on the latest procedures and technology, says Lois Margaret Nora, MD, JD, MBA, president and chief executive officer of ABMS. "Legislation being introduced in states across the country increases the potential for patients and families to receive substandard care by either reducing access to board certified medical specialists, or by lowering the standards for specialty medical practice," Nora told *Medical Economics* in an email.

Grant Greenberg, MD, MHSA, medical chairman at Lehigh Valley Health Network in Allentown, Pennsylvania, believes state legislators should steer clear of hospitals' decisions about staff privileges and leave those to medical administrators.

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>
> — JANE ORIENT, MD, EXECUTIVE DIRECTOR, THE AMERICAN ACADEMY OF PHYSICIANS AND SURGEONS

"Board certification is establishing a minimum standard of competency, based on the expertise of physicians practicing in the field, who are knowledgeable about the field, who teach in the field, about what someone should know to be deemed competent in that field," he says. The anti-MOC movement has come about, in his view, "because there's a few bitter people who don't like having to pay money to the board, or take a test or do a quality improvement project."

Greenberg also notes that some of the ABMS boards, including the American Board of Internal Medicine and the American Board of Family Medicine, have attempted to address at least a few of the concerns of people who find the testing process onerous.

They are doing so "by providing a wider array of easier, more accessible options that still maintain the integrity in terms of minimum standards, and yet make it administratively less difficult or time-consuming," he adds. "Boards are going in a good direction with respect to that."

But until they encountered opposition from NBPAS, the ABMS boards had been aggressively expanding their testing regimes and advocating their use, says Jane Orient, MD, executive director of the American Academy of Physicians and Surgeons (AAPS), and an internist based in Tucson, Arizona.

"Since doctors don't think their program is that worthwhile, they need to have it forced upon them by state legislation, or by hospitals," she says, adding that the AAPS favors using state legislation to limit the use of MOC for purposes such as admitting privileges.

She adds that when MOC is required by hospitals or insurers, "One day you're qualified, the next day you missed one too many exam questions and you're no longer qualified, and patients are left without their doctor."

GEORGIA PASSES FAR-REACHING MOC BILL

The Georgia bill initially limited all potential uses of MOC, including for admitting privileges at private hospitals in addition to those at state-owned facilities. However, the limitation on private hospitals was dropped as part of a compromise during the legislative process, says Steven Walsh, MD, an anesthesiologist and president of the Medical Association of Georgia.

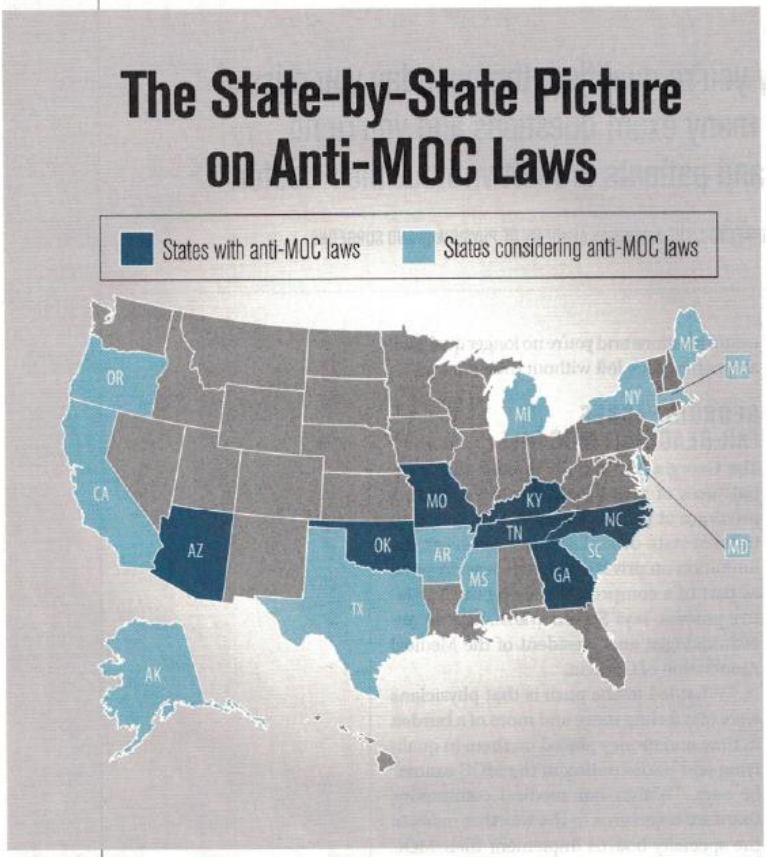
"What led to the push is that physicians were just feeling more and more of a burden in time and money placed on them in qualifying and participating in the MOC exams," he says. "Within our medical community, there are objections to the way that many of the specialty boards implement their MOC process."

Cody McClatchey, MD, a board member of the Medical Association of Atlanta and chair of the public policy committee of the Georgia chapter of the American College of Physicians (ACP), says physicians in the state are very pleased with the new law. While there could be "some friction" about the provision regarding staff privileges at private hospitals being stripped from the bill, he hasn't heard much discontent about that compromise to date.

McClatchey, an internist in Atlanta, believes doctors in his state are taking a wait-and-see approach to ABMS member boards' actions to respond to physician concerns. "We're still in kind of a transitional time for that," he says. "They're moving in the right direction, and there seems to be dialogue."

Physicians in the state are committed to continuous education, but ABMS testing gets too far into minutiae and covers areas

The State-by-State Picture on Anti-MOC Laws



STATES WITH ANTI-MOC LAWS

TENNESSEE: The existing law only addresses licensure, but efforts to prohibit MOC from being used to determine hospital privileges or insurance eligibility may be revived in future legislative efforts.

GEORGIA: The law prohibits MOC from being used for state licensure, eligibility for health insurance panels, eligibility for malpractice insurance and staff privileges at state-owned hospitals.

OKLAHOMA: Physicians do not have to secure MOC "as a condition of licensure, reimbursement, employment of admitting privileges at a hospital in this state."

KENTUCKY, MISSOURI, ARIZONA AND NORTH CAROLINA: The law prohibits the state licensure board from either requiring MOC or creating any form of "maintenance of licensure" tied to MOC.

irrelevant to a physician's practice, says Jacqueline Fincher, MD, a partner at the Center for Primary Care in Thomson, Georgia, and board of regents member for the ACP's Georgia chapter.

"This law enables internists here in Georgia not to have to worry about losing their credentials," she says. "State licensure has certain criteria you have to meet every year in terms of continuing education. Patients want to know their doctor is knowledgeable and treats them well. I've never had a patient ask me if I'm board-certified."

Fincher says that while she finds it somewhat disappointing that private hospital privileges were excluded from the bill, they might feel pressured to drop the requirement anyway. "The private hospitals, if they choose not to implement this [voluntarily], they risk losing physicians," she says. "I think that will resolve itself."

TEXAS POISED TO FOLLOW GEORGIA'S LEAD

The Texas bill, cosponsored by two physicians, limits MOC use for licensure, insurance reimbursement and staff privileges at non-academic, non-cancer center hospitals. Others may limit MOC's use for these purposes, but that decision must be made at the individual hospital level and not corporation-wide for those hospitals that are part of larger groups, says Carlos J. Cardenas, MD, president of the Texas Medical Association.

"It empowers each independent medical staff to opt out of the MOC requirement," says Cardenas, a gastroenterologist at Doctors Hospital at Renaissance in Edinburg, Texas. "It's the medical staff, rather than a corporate entity, saying what it [the MOC policy] is going to be."

In a state where about two-thirds of physicians are in either sole proprietorships or two-doctor offices, Cardenas thinks that the majority of his colleagues believe that MOC had grown "out of touch with the practice of medicine, in terms of what they were doing in their own specialties," he says.

"The concern on the other side was, 'What will be the metric?'" But he adds that state licensure and continuing medical education (CME) seemed adequate to most physicians in the state.

Testifying on behalf of the Texas Medical

Association, Kim Monday, MD, a neurologist from Houston, told the Public Health Committee of the state's House of Representatives that MOC could be compared to attorneys needing to retake the bar exam every 10 years.

"Most physicians feel initial board certification is necessary to validate expertise following residency and training programs," Monday said. "However, we find the continuous maintenance of certification process to be burdensome, expensive and filled with irrelevant curriculum."

TENNESSEE LAW FOCUSES ON LICENSURE

The Tennessee law enacted in May addresses only licensure, although an earlier version would have prohibited use of MOC to determine hospital privileges or insurance eligibility, says Dave Chaney, vice president of the Tennessee Medical Association.

But Chaney suspects those provisions may be revived in the next legislative session. "This is something that has been brewing for a number of years," he says. "We've heard from a lot of our members who incur what they feel is excessive cost and an unnecessary burden to complete the exams and the studies to maintain their specialty board certification."

The Tennessee Medical Association believes board certification should be entirely voluntary, "yet [doctors] don't feel they have a choice when the hospitals and payers say it's a requirement," he adds. "Our members are happy we're taking up the flag and doing something about it. As with any advocacy issue, you don't always hit a home run on the first swing."

State Senator Richard Briggs, MD, a cardiothoracic surgeon and sponsor of the bill, says he "absolutely" intends to revive the other aspects of the original bill related to hospital privileges and insurance eligibility.

As an adult open heart surgeon, Briggs says he has had to answer questions about everything from heart transplants to pediatric heart surgery on MOC exams. "Why should I take time and money to take courses on those [issues]?" he says. "You're spending time that has absolutely nothing to do with your practice."

OTHER STATES

At least three other states had bills pending that did not pass in the spring of 2017. A Florida bill that would have prohibited MOC from being used in determining hospital privileges and insurance eligibility made it through a House committee, but not the full House.

The Florida bill enjoyed the support of three physician-legislators, including State Rep. Julio Gonzalez, MD, an orthopedic surgeon in Venice, Florida, and the bill's sponsor. "All three of us were in lockstep in espousing and believing in the virtues of this bill," he says. "The concept was very straightforward."

But the state's Senate, which does not have any doctors among its members, changed the bill significantly and it did not pass, Gonzalez says. "Number one, they don't understand the economics and industry dynamics because they don't have a physician in their chamber," he says of the Senate. "Number two, pressure was applied by the hospitals and insurance industry, and ABMS hired a lobbyist to lobby against the bill." He adds that he plans to reintroduce the bill in 2018.

Rhode Island's legislature held hearings on a bill but has tabled it for further study. House minority leader Patricia Morgan still hopes it will progress. "[Doctors] don't think [MOC] improves their skills and knowledge, but it certainly adds a lot of cost and time," she says. "They say it's just an added layer of requirements on them."

However, Peter Hollmann, MD, vice president of the Rhode Island Medical Society, says he doesn't think many doctors in his state see the need for legislation limiting the use of MOC, and hopes the legislation doesn't pass.

"In general, we support medical staffs being autonomous" to make decisions on what's needed for hospital privileges, says Hollmann, a geriatric internist and chief medical officer of University Medicine, a medical center affiliated with Brown University. "We'd rather not have legislators telling us what to do."

But Hollmann adds that the feeling isn't quite unanimous and that a minority of physicians saw the bill as a bulwark against what they view as onerous requirements. "In our community, there are a small number of doctors who are very, very, very concerned about this," he says. ◘