

AWARD-WINNING MAGAZINE OF THE MICHIGAN STATE MEDICAL SOCIETY

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[www.msms.org](http://www.msms.org)

# Michigan Medicine

**It's Time**  
*for* **Change!**

**RIGHT**  
**2**  
**CARE**

Conversations About  
**MAINTENANCE OF  
CERTIFICATION**



# A Unified Voice Is Needed To Affect Change: Maintenance of Certification in Michigan

BY ROSE M. RAMIREZ, MD

## Maintenance of Certification

This issue of *Michigan Medicine* is highlighting issues related to Maintenance of Certification (MOC); however, secondarily, I would also like to share a brief update on Advance Care Planning (ACP) in Michigan.

First, a little history... The American Board of Medical Specialties (ABMS) is the parent organization of the 24 core boards and their subspecialties. Board certification began in 1917 with the American Board of Ophthalmology as the first specialty board. The American Board of Internal Medicine (ABIM) was incorporated in 1936. Forty-two years ago, the ABIM officially endorsed the principle of recertification, but decided to implement it on a voluntary, rather than mandatory basis.

By 2002, the core group of the 24 member boards of the ABMS had a firm set of shared guidelines and requirements for board certification. Over time, MOC has become a mandate rather than a recommendation.

In the April 15, 2010 issue of *The New England Journal of Medicine*, an article discussing the results of a poll of members regarding board recertification was published.

Specifically, many readers felt that the cost of MOC far outweighed the educational benefit and that the MOC program was essentially a money-generating activity for the ABIM. Others felt that the exercise was only marginally relevant to their day-to-day practice and that it took their time away from patients and other learning activities.

In January 2014, the ABIM substantially increased the requirements and fees for its MOC program. Internists will now incur an average of \$23,607 in MOC costs over

10 years, ranging from \$16,725 for general internists to \$40,495 for hematologists-oncologists. Time costs account for 90% of MOC costs.

Faced with mounting criticism, the ABIM suspended certain content requirements in February 2015 but retained the increased fees and number of modules.

In 2014, when the ABIM issued the new requirements for maintaining certification, Paul Teirstein, MD, (chief of cardiology at Scripps Clinic in San Diego) and his colleagues declared "enough." They formed a new recertification organization called the National Board of Physicians and Surgeons (NBPAS). The NBPAS fees are much, much lower than those charged by the ABIM and its board and management—all top names in medicine—work for free. The goal is to break the monopoly the ABMS has on MOC and put leadership back into the hands of practicing physicians.

Here in Michigan, another approach to the onerous and expensive requirements of MOC includes legislative proposals by Senator Peter MacGregor and Representative Edward Canfield, DO, to remove the requirement by insurers of board recertification as a prerequisite to payment for health care services. The bills are currently in the Senate and House Health Policy committees. Please visit <http://right2care.org> for the latest information.

The Pennsylvania Medical Society held a forum on MOC at the American Medical Association Interim meeting in November. It was well attended by practicing physicians and by leadership from many of the Specialty boards. I think ABMS

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I hope your holidays  
were full of thankfulness  
and joy! Based on some  
recent studies, people who  
experience gratitude and  
happiness live longer  
and are healthier!

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“We will need the unified physician voice to make a change in the deeply entrenched powers that want to maintain the MOC status quo. That’s why MSMS developed it’s campaign, ‘Right2Care’. I encourage each of you to visit <http://right2care.org>, where you may contact your lawmakers and contribute to fight this bureaucratic nightmare.”

and its core members are finally getting the message that MOC needs to change.

One big challenge is that The Affordable Care Act (ACA) modified Sections 1848(k) and 1848(m) of the Social Security Act which defines how CMS pays physicians for their services. For 2013 and 2014, the “Quality Reporting System” portions included requirements of MOC in the registry reporting section and gave payment incentives. In 2015, reporting on MOC was still required, but incentive payments were no longer included.

And even though the mantra from the ABMS attempts to sell MOC as a “Trusted Credential”, the ABMS uses empirical evidence to make its claim of the value MOC brings to health care and has yet to prove that the value is greater than the cost. However, because hospitals and payers want a way to show that their physicians are high quality, this is one surrogate they use. Various quality organizations and health care purchasers also use this ‘credential’ to show value.

At the recent Interim meeting, the AMA House of Delegates approved the Report 2 from the Council on Medical Education which includes the AMA principles on MOC. This report reviews and consolidates existing American Medical Association (AMA) policy on MOC, Osteopathic Continuous Certification (OCC) and Maintenance of Licensure (MOL) to ensure that these policies are current and coherent.

We will need the unified physician voice to make a change in the deeply entrenched powers that want to maintain the MOC status quo. That’s why MSMS developed it’s campaign, ‘Right2Care’. I encourage

each of you to visit <http://right2care.org>, where you may contact your lawmakers and contribute to fight this bureaucratic nightmare.”

### Advanced Care Planning (ACP)

Before I conclude, I want to briefly discuss some of the Advance Care Planning (ACP) work going on in our state. ‘End of Life Care’ is one of our current Michigan State Medical Society (MSMS) strategic objectives and we have an opportunity to collaborate with a number of communities in our state already working on ACP and essentially following the Gunderson Lutheran Respecting Choices model. This ACP model provides an evidence-based process with a standardized approach to conversations with patients and their families about end of life care.

#### First Steps:

Introduce ACP and basic documentation.

#### Next Steps:

Discuss ACP again when chronic illnesses become more advanced.

#### Final Steps:

Discussions with frail, elderly or when a patient may die within next 12 months.

More complete documentation such as Physician Orders for Life Sustaining Treatment (POLST or MI-POST).

As these documents are completed, they will be uploaded to a statewide registry. While community volunteers, clergy and others can participate in First Steps, medical professionals are needed for the Final Steps. Medicare will begin to reimburse for time spent counseling patients on end of life care beginning in 2016.

Some of the components that make this program successful are the community approach, the availability of information as standard practice and education of healthcare professionals. Other components include the careful scripting of the conversations and the training of physician and other non-physician advance care planning facilitators.

Other states have used their state medical societies to promote ACP programs. The two organizations in our state working on this are “makingchoicesmichigan.org” and “honoringhealthcarechoicesmi.org”. John McKeigan, MD, was one of the founding members of Respecting Choices Michigan, which has been mostly focused in West Michigan.

At the October 7, 2015 MSMS Board meeting, a motion was approved to “request more comprehensive information on the Gunderson Respecting Choices model and an analysis of the feasibility of our MSMS leading this initiative statewide.” The motion was passed unanimously. More information will be forthcoming! **MM**



Doctor Ramirez, a Kent County family physician, is president of the Michigan State Medical Society



# Is Maintenance of Certification A Violation of the Antitrust Laws?

BY DANIEL J. SCHULTE, JD, MSMS LEGAL COUNSEL

## QUESTION:

*It was reported a year or two ago that a lawsuit alleging that Maintenance of Certification ("MOC") violated the anti-trust laws. Was this lawsuit filed by the government or a private party? Can you explain what this lawsuit alleged specifically regarding antitrust law violations? I assume the case was either unsuccessful or has not been decided because if MOC was illegal we would not still talking about it. Can you update us on this?*

## ANSWER:

You must be referring to the Association of American Physicians & Surgeons' ("AAPS") lawsuit against the American Board of Medical Specialties ("ABMS"). The AAPS filed its Complaint against ABMS back on April 23, 2013. Neither the Federal Trade Commission nor the U.S. Department of Justice are involved in the case nor is any state anti-trust enforcement agency.

In its Complaint, AAPS seeks:

1. a declaratory judgment that the ABMS has violated the antitrust laws (specifically Section 1
2. an injunction against ABMS prohibiting it from continuing to engage in its restraint of trade (i.e. the MOC Program);
3. a refund of fees paid by AAPS members who have complied with the ABMS MOC program;
4. an injunction prohibiting ABMS from continuing to make certain false statements in connection with the MOC program; and
5. reimbursement of its attorney fees.



Daniel Schulte, JD,  
MSMS Legal Counsel,  
is a member of  
Kerr Russell Attorneys  
and Counselors

AAPS alleges the existence of several agreements entered into by ABMS and at least two dozen other entities to impose on physicians the recertification program known as ABMS MOC\*. The other entities include health plan administrators, health insurers, hospitals and other health facilities. The Complaint further alleges that ABMS is acting in concert with The Joint Commission so that the more than 20,000 healthcare organizations and hospitals accredited by The Joint Commission will require MOC compliance by those physicians on their medical staffs as a condition of renewal of their privileges. According to AAPS, ABMS together with the other entities and The Joint Commission have formed a conspiracy to illegally restrain competition in the market for physician services by excluding physicians who do not comply with the MOC program from continuing to practice in hospitals and other health facilities and terminating their participation in health plan/health insurer networks. AAPS alleges that the effect of this conspiracy to illegally restrain competition is a limitation on patient's access to their physician of choice.

The injunction sought to prohibit ABMS from continuing to make certain false statements relates to ABMS' use of "Not

Meeting MOC Requirements" to describe physicians who chose not to comply with MOC. AAPS alleges that this statement creates the false impression that MOC is a "requirement" that is indicative of the medical skills of these physicians and that physicians that do not comply with the MOC "requirement" are somehow less competent than those that do. AAPS also seeks to prohibit ABMS from continued use of its website named "certification matters" which, AAPS alleges, invites the public to search on specific physicians and falsely implies that physicians who do not comply with MOC are somehow less competent physicians. AAPS alleges that these are all false representations since ABMS has no support for and cannot demonstrate a significant correlation between MOC compliance and superior medical skills.

The procedural history of this case is a bit out of the ordinary. The Complaint was filed on April 23, 2013. AMBS moved to dismiss the case in May of 2014. This motion to dismiss was fully briefed as of July of 2014 but the court (Federal District Court for the Northern District of Illinois) has not yet ruled. MSM legal counsel will continue to monitor the case and report on developments when they occur. **MM**



# It's Time *for* Change!

## Conversations About Maintenance of Certification

Maintenance of Certification brings up one consistent question among Michigan physicians: **Why?**

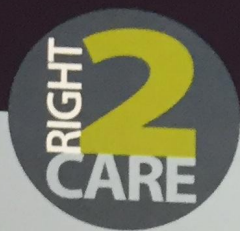
**Why** are we paying thousands of dollars to bring zero value to our patients?

**Why** are we subjected to redundant, non-specialized modules and procedures?

**Why** is MOC continuing to be regulated?

In this issue of *Michigan Medicine*, we talk to three physicians about their frustrations with MOC and how this bureaucratic requirement is affecting their practice and patients. Their stories and many others are fueling change and inspiring advocacy campaigns such as Michigan State Medical Society's recent **Right 2 Care** ([www.right2care.org](http://www.right2care.org)) initiative, which aims to eliminate unnecessary requirements in Michigan.





## Patients and Physicians in Michigan have a Right 2 Care

Michigan Patients have a right to high quality health care from a physician of their choice.

Michigan Physicians have a right and a responsibility to deliver high quality care to their patients.

Those rights are at risk because of a bureaucratic nightmare known as "Maintenance of Certification," and a reckless new health insurance company plan that could cut off patients' access to the physicians they know and trust!

That's not just a hassle- that's dangerous.

### What is Maintenance of Certification?

As physicians' careers advance, they take part in continuing medical education programs that help them keep current with advancements in medicine and patient care. The costs of this testing and training are paid by each physician, and are necessary to allow them to practice in Michigan.

Here's the problem: the American Board of Internal Medicine, or ABIM, devised a way to make huge profits through regular, additional, duplicative and unnecessary Maintenance of Certification (MOC).

Now, some health plans and insurance companies in Michigan are threatening to cut off patients' access to their highly trained, highly qualified physicians unless those physicians jump through bureaucratic hoops.

### How does Maintenance of Certification Hurt Patients and Physicians?

Physicians already maintain education requirements to keep their licenses to practice medicine and have the right to deliver high quality health care to their patients, but:

- Maintenance of Certification is an out-of-state scheme that drives up the cost of health care while limiting physicians' time with their patients.
- A new health insurance company plan may use MOC to force some patients to leave the physicians they've grown to know and trust.

### Defending Michigan Patients Right 2 Care.

Patients deserve access to high quality health care. New legislation in Lansing would make sure they get it.

Senate Bills 608 and 609 and House Bills 5090 and 5091 will protect and defend:

- A patient's right to the health care and support they need from the physician they choose.
- A physician's right to provide quality care to patients without costly, troublesome "pay to play" requirements.
- A state's right to create a health care system that works for everyone.

**MSMS is proud to have established the R2C campaign to fight MOC.**

**We need *your* financial support to be successful. It's time to fight for Michigan's Right 2 Care.**

**Contribute today at <http://right2care.org>.**



**Megan M. Edison, MD**  
Pediatrician,  
Brookville Pediatric  
and Internal Medicine



**Q: When did you begin advocating against MOC and why?**

**A:** Like many pediatricians, my concerns with MOC started in 2010 when the American Board of Pediatrics again revised their program to a more expensive and ongoing MOC program, without any evidence these changes would improve patient care. Pediatricians tried to voice our concerns, but we felt alone and easily intimidated in the fight.

It really wasn't until the past two to three years when American Board of Internal Medicine tried to force these same continuous MOC programs on the internists that this issue really gained attention. Since then, we've all come together as physicians to speak out against this MOC scheme affecting us all.

I am a young pediatrician, with 25 years left in my career. In just eight years, I've watched the 'mission creep' of MOC go from an open book every seven years, to a secure exam every seven, to the five year cycles of secure testing, online testing and practice improvement modules it is now. The American Board of Pediatrics is already starting discussion of weekly testing and direct access to our charts for research data. At a certain point, we have to get involved in the process, and say 'enough.'

**Q: Tell me about a situation when MOC clearly affected your practice and/or one of your co-workers' practice.**

**A:** In Michigan, the issue of MOC is more pressing for our physicians than for doctors in other states because Blue Cross Blue Shield of Michigan (BCBSM) requires board certifica-

tion and MOC to participate. In other states, doctors can simply choose not to participate in MOC without consequence. In Michigan, doing so will result in loss of insurance participation.

This isn't just an idle threat by BCBSM. This year, one of my partners was a few weeks late turning in data for a 'hand washing module', where patients rate our hand washing and the data is sent to the American Board of Pediatrics. He was immediately notified by BCBSM that he could no longer see his BCBSM patients until he complied with MOC. This means these out-of-state board corporations with their ever-changing MOC requirements have incredible power to end relationships between doctors and patients.

**Q: Tell me about your involvement in the Right 2 Care campaign and why you feel that this campaign will help bring change.**

**A:** My involvement in the Right 2 Care issue dates back to helping write the very first anti-MOC resolutions at the 2013 House of Delegates, and then sitting on committees in the 2014 and 2015 House of Delegates listening to my colleagues present their anti-MOC resolutions. The passion and unity of physicians around MOC is simply unprecedented. It's exciting to be part of the process where physician concerns become resolutions, resolutions become MSMS policy and now hopefully MSMS policy becomes state law.

If Michigan becomes the first 'Right 2 Care' state, meaning MOC would not be required for a medical license, insurance participation

**“If Michigan becomes the first ‘Right 2 Care’ state—meaning MOC would not be required for a medical license, insurance participation or hospital privileges—many positive transformative changes would happen for doctors and our patients.”**



or hospital privileges, many positive transformative changes would happen for doctors and our patients. Michigan doctors would be free to choose continuing medical education that best suits our needs and our unique patient populations, rather than the limited proprietary products from the boards. We would be free to pursue relevant clinical research and novel practice improvement projects, rather than the irrelevant projects chosen by the boards.

Right 2 Care legislation would improve medical access and patient choice, as doctors won't be dropped from insurances for not participating in MOC and our more experienced doctors won't be considering early retirement to avoid another costly and time consuming MOC cycle.

**Q: If MOC were to continue being regulated, what would you change about it to make it more reasonable and relevant for doctors?**

**A:** I don't believe the American Board of Medical Specialties and their boards will change their highly lucrative MOC program unless doctors are given a choice to stop participating or are allowed to certify through competing boards like the National Board of Physicians and Surgeons. Only when we are given freedom to choose, will change happen.

Any MOC requirements must be straightforward, egalitarian, inexpensive, and physician-focused. After certifying, re-certifying and re-re-certifying through the American Board of Pediatrics, I have had enough. I am currently maintaining my pediatric board certification through the National Board of Physicians and Surgeons, because their requirements reflect my ideals of what MOC should be: Pass the board examination once, hold an active, unrestricted state medical license and demonstrate commitment to ongoing education through 50 hours of Continuing Medical Education (CME) every two years. That is more than adequate.



*Megan M. Edison, MD and Srinivas K. Janardan,*



**Srinivas K. Janardan, MD**  
**Gastroenterologist,**  
**Grand River**  
**Gastroenterology**



**“I believe the MOC process is an outdated method, even though it was just started in the last few years. It does not address how physicians practice. It does not take into account how physicians research information and collaborate with other physicians. It does not address how physicians learn as practicing physicians rather than as residents and fellows.”**

**Q: When did you begin advocating against MOC and why?**

**A:** I have been involved in the certification and recertification process for the American Board of Internal Medicine for the last 20 years. I initially took my Internal Medicine boards in 1991; in 1995, I took my gastroenterology boards. I've elected not to recertify in Internal Medicine. I have retaken my Gastroenterology boards in 2005 and most recently in 2015. In the last two years, I have been very disappointed with the new requirements of the MOC process.

The high failure rate in Gastroenterology boards has made this a very stressful test. It is this that has led me to be very active in opposing the MOC requirements. When looking at the pros and cons of the MOC, it is clear that it does not add value to me as a clinician or to my care of my patients. It has become a right of insurability and paperwork. It has become a very stressful event with no significant game. I do not find it helpful as a form of education. I do not find it helpful in improvement of my practice. The endless number of practice improvement modules are worthless for gastroenterology. There is significant overlap with multiple other agencies and requirements for us as physicians. The excessive cost, time requirements and time away from family has made these MOC requirements unreasonable.

In July 2013, I was elected Chief of Staff at Mercy Health St. Mary's (MHSM). During the same time, I have had to recertify in Gastroenterology. As Chief of Staff, I sent out a survey and fact-finding email to all of the medical staff at MHSM. Many medical staff shared my opposition to the recertification and MOC process. I received numerous emails from the medical staff in support of my efforts to overturn this process. Recently, I have been elected to the board of MHSM. In this position, I have presented this same opposition and asked for support to oppose requiring the MOC for the medical staff. It is my hope that we will get MHSM bylaws changed in the near future. Unfortunately, insurance companies such as Blue Cross Blue Shield have been unwilling to change or look for alternative certification. It is this reason that I believe state legislation will be necessary.

**Q: Tell me about a situation when MOC clearly affected your practice and/or one of your co-workers' practice.**

**A:** I have seen high quality physicians fail the test and then be dropped from insurance reimbursement. In addition, I have seen physicians who came from abroad that are not allowed to take these tests. As such they have been excluded for participating in insurance company reimbursement. These are world experts that are excluded from practicing here in Grand Rapids. Again, for no specific reason apart from rigid requirements. In the end, our patients are losing high quality care.

**Q: If MOC were to continue being regulated, what would you change about it to make it more reasonable and relevant for doctors?**

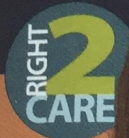
**A:** I believe the MOC process is an outdated method, even though it was just started in the last few years. It does not address how physicians practice. It does not take into account how physicians research information and collaborate with other physicians. It does not address how physicians learn as practicing physicians rather than as residents and fellows.

The Gastroenterology associations are starting a process of continuing education that would be far superior to the MOC methodology. Our Gastrointestinal (GI) societies are going to be very active in overriding the American Board of Internal Medicine MOC. It is my hope that this will become a reality within the next one to two years. Certainly, I hope I will not have to go through the recertification and MOC process for last 15 years of my career!



## Josephine P. Dhar, MD

Chief and Program Director,  
Internal Medicine,  
Central Michigan University  
School of Medicine;  
Adjunct, Internal Medicine,  
Wayne State University  
School of Medicine



Josephine P. Dhar, MD

### **Q: When did you begin advocating against MOC and why?**

**A:** It was through the Michigan State Medical Society (MSMS) that I originally became involved. I'm on the editorial board and I very clearly started to express my opinion on MOC and that it's a burden on the practice.

I've been in an academic setting, and so I appreciate the difference between an academic setting and a private office or community setting. We have the advantage of having training programs [at Central Michigan University School of Medicine] and so for us, it's not as difficult. But for people that practice to start implementing these type of educational activities in their office, it's just overly burdensome.

When I did the MOC modules, there were no modules for Rheumatology, which I thought was silly. So in my busy academic practice, I was doing modules on cardiovascular disease and hypertension which did nothing to improve my patient care. I'm a rheumatologist and there were no rheumatology MOC modules.

### **Q: Tell me about a situation when MOC clearly affected your practice and/or one of your co-workers' practice.**

**A:** I just remember walking in to a patient's room and saying 'do you mind doing this questionnaire for me because I need to do it for my certification.' It was just odd to ask them to help me get my certification. And then after that, I would still have to extract data from their chart into my questionnaire because it requires certain information. I just remember patients saying 'Why are you doing this Doctor Dhar?' and they always said, 'Okay, I'll help you.' The patients were really nice, I think the patients are just wonderful trying to help their doctor.

It was an imposition on the visit, and then I had to explain to the patient it wasn't research, I had to do it for my course. It's just awful the way you have to insert it into your practice. Not only did it not help my practice, but it interfered with the patient.

### **Q: If MOC were to continue being regulated, what would you change about it to make it more reasonable and relevant for doctors?**

**A:** I don't understand what the purpose of MOC is. We're required to get continued education and credits every year and most of us are attending specialized meetings and so we're already learning about our field. How is MOC different than that? **MM**

**To learn more about MOC and the Right 2 Care initiative, visit [www.right2care.org](http://www.right2care.org) and join the fight.**