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3 Title: Initiate Legal Action Against Hospitals and Insurers
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5 Introduced by: Domenic Federico, MD, for the Kent County Delegation
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7 Original Author: Megan Edison, MD
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9 Referred to: Reference Committee C
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11 House Action: **AMEND**
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14 Whereas, MSMS has had policy in place for 19 years opposing the use of board certification as
15 the sole criterion for credentialing or exclusion of physicians in health care plans, and
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17 Whereas, MSMS policy on maintenance of certification (MOC) was further refined in 2015 to
18 oppose MOC as a condition of licensure, hospital privileges, health plan participation, and
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20 Whereas, Michigan health insurers and hospitals continue to ignore repeated requests by
21 MSMS to remove active American Board of Medical Specialties (ABMS) specific board certification as a
22 requirement, despite this MSMS policy being in place for nearly two decades, and
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24 Whereas, Michigan hospitals continue to ignore federal code CFR 482.12 which states “Ensure
25 that under no circumstances is the accordance of staff membership or professional privileges in the
26 hospital dependent solely upon certification, fellowship, or membership in a specialty body or
27 society,” and
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29 Whereas, Michigan insurers and hospitals only allow board certification through the ABMS,
30 refusing requests to allow physician choice in board certifying entities, thus stifling competition and
31 creating a monopoly, and
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33 Whereas, Michigan insurers are a national outlier in their aggressive exclusion and
34 departicipation of physicians who choose not to participate or purchase the ABMS MOC product, and
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36 Whereas, there is a shortage of physicians to provide care for the demand of Michigan
37 patients, and
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39 Whereas, discriminatory exclusion of physicians based upon ABMS MOC participation
40 exacerbates the physician shortage, worsens access, and requires patients to find new doctors, and
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42 Whereas, the actions of Michigan hospitals and health insurers, by requiring time-limited
43 ABMS diplomates to purchase the onerous and expensive ABMS MOC product in order to care for
44 patients, have created a discriminatory monopoly situation that is a restraint of trade, harming both
45 physicians and patients; therefore be it
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47 RESOLVED: That MSMS engage with MSMS Legal Counsel to determine whether a viable
48 cause of action exists against Michigan hospitals and/or insurers that require American Board of
49 Medical Specialties Maintenance of Certification as a requirement for (1) medical staff membership,
50 privileging, credentialing, or recredentialing or (2) insurance panel participation, are in violation of
51 anti-trust laws including the Sherman Act; and be it further
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53 RESOLVED: That MSMS work with our American Medical Association (AMA) and our AMA’s
54 Litigation Center to determine whether the maintenance of certification programs and/or policies of

55 the American Board of Medical Specialties and/or any of the ABMS Medical Boards are in violation of
56 anti-trust laws including the Sherman Act.

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59 WAYS AND MEANS COMMITTEE FISCAL NOTE: This request would require MSMS to engage with legal
60 counsel. Estimates range from \$200,000 – \$300,000.

Relevant MSMS Policy:

Recertification Requirements for Employment

MSMS opposes recertification as a condition of employment. (Res79-01A)

– Edited 2016

Review Board Recertification and Maintenance of Certification Process

MSMS supports Maintenance of Certification (MOC) only under all of the following circumstances:

1. MOC must be voluntary
2. MOC must not be a condition of licensure, hospital privileges, health plan participation, or any other function unrelated to the specialty board requiring MOC
3. MOC should not be the monopoly of any single entity. Physicians should be able to access a range of alternatives from different entities.
4. The status of MOC should be revisited by MSMS if it is identified that the continuous review of physician competency is objectively determined to be a benefit for patients. If that benefit is determined to be present by objective data regarding value and efficacy, then MSMS should support the adoption of an evidence based process that serves only to improve patient care.

(Res73-15)

Credentialing or Exclusion of Physicians in Health Care Plans

MSMS opposes the use of board certification as the sole criterion for credentialing or exclusion of physicians in health care plans. (Board-July98)

Relevant AMA Policy:

Maintenance of Certification H-275.924

AMA Principles on Maintenance of Certification (MOC)

1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for MOC.
4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part II. The

content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 Credit™, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."

10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.

11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.

12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.

13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.

14. MOC should be used as a tool for continuous improvement.

15. The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.

16. Actively practicing physicians should be well-represented on specialty boards developing MOC.

17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.

18. MOC activities and measurement should be relevant to clinical practice.

19. The MOC process should not be cost prohibitive or present barriers to patient care.

20. Any assessment should be used to guide physicians' self-directed study.

21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.

22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.

23. Physicians with lifetime board certification should not be required to seek recertification.

24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC.

25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.

Maintenance of Certification and Osteopathic Continuous Certification D-275.954

Our AMA will:

1. Continue to monitor the evolution of Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for MOC, and prepare a yearly report to the House of Delegates regarding the MOC and OCC process.

2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOC and OCC issues.

3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of MOC, and encourage the ABMS to report its research findings on the issues surrounding certification and MOC on a periodic basis.

4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and MOC.

5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of MOC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.

6. Work with interested parties to ensure that MOC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that MOC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.

7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from MOC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting MOC and certifying examinations.
10. Encourage the ABMS to ensure that MOC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. Work with the ABMS to lessen the burden of MOC on physicians with multiple board certifications, particularly to ensure that MOC is specifically relevant to the physician's current practice.
12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for MOC; (b) support ABMS member board activities in facilitating the use of MOC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet MOC requirements.
13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Work with the ABMS to study whether MOC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce.
15. Encourage the ABMS to use data from MOC to track whether physicians are maintaining certification and share this data with the AMA.
16. Encourage AMA members to be proactive in shaping MOC and OCC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and MOC Committees.
17. Continue to monitor the actions of professional societies regarding recommendations for modification of MOC.
18. Encourage medical specialty societies' leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant MOC process for its members.
19. Continue to work with the ABMS to ensure that physicians are clearly informed of the MOC requirements for their specific board and the timelines for accomplishing those requirements.
20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
21. Recommend to the ABMS that all physician members of those boards governing the MOC process be required to participate in MOC.
22. Continue to participate in the National Alliance for Physician Competence forums.
23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of MOC.
24. Continue to assist physicians in practice performance improvement.
25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's MOC and associated processes.
26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the MOC program.
27. Oppose the maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Maintenance of Certification.
28. Examine the activities that medical specialty organizations have underway to review alternative pathways for board recertification; and determine if there is a need to establish criteria and construct a tool to evaluate if alternative methods for board recertification are equivalent to established pathways.
29. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on maintenance of certification activities relevant to their practice.
30. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.

31. Support a recertification process based on high quality appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.
32. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.
33. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.
34. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Maintenance of Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.
35. Increase its efforts to work with the insurance industry to ensure that maintenance of certification does not become a requirement for insurance panel participation.