August 18, 2017

Lois M. Nora, MD, JD, MBA
American Board of Medical Specialties
353 North Clark Street
Suite 1400
Chicago, IL 60654

Dear Dr. Nora,

We know that maintenance of certification (MOC) has been a contentious issue between physicians and certifying boards for a host of reasons. Many physicians have looked to their national specialty and state medical societies to provide leadership in addressing these concerns. This letter is to inform you of two meetings—a high-level summit that recently took place to discuss these problems, and a meeting this December with the American Board of Medical Specialties (ABMS), the Council of Medical Specialty Societies (CMSS), and state medical societies to directly share our views and seek agreement on how to reshape the MOC process to the betterment of our physicians and the patients in their care.

On Wednesday, July 26, 2017 a small group of national medical specialty society and state medical society CEOs gathered to follow up on Maintenance of Certification, MOC, discussions that occurred during the June AMA meeting. The crisis impacting MOC had been discussed separately during the Specialty Society CEO Coalition (S2C2), the State CEO meeting, and during AMA's Annual CEO meeting where MOC was not on the agenda but quickly became the dominant topic. The leaders who gathered in Minneapolis, like you, recognize that issues with MOC programs have created an unintended threat to quality patient care. As physicians, we want patients to receive the right care, at the right time, in the right place, by well-trained physicians. Recognizing that this goal is shared by certifying boards, our national medical specialty societies and our state medical societies are now sharing what we see as the issues and, potential unintended consequences of the current MOC program and an opportunity to collectively address these concerns.

Attached to this letter in Appendix A is a listing of the issues discussed. Appendix B is a current tabulation of state legislative activities, successful and pending, which threaten our right to professional self-regulation. As delineated in these issues, professional self-regulation is under attack. Concerns regarding the usefulness of the high-stakes exam, the exorbitant costs of the MOC process, and the lack of transparent communication from the certifying boards have led to damaging the MOC brand, and creating state-based attacks on the MOC process.

The July 26 discussion was very encouraging. While the problems are clear, there are opportunities to redirect the process. After all, this is about physician self-regulation and not MOC. This is about keeping patients first and doing all we can to ensure high quality patient care. Some boards have already recognized the problems and are responding. Together, we must fix the problem both in the short term and long term. If action is taken, we believe the state medical society legislative solution agenda may be mollified. There was unanimity amongst the national medical specialty society and state medical society leaders in wanting to work with the leaders of our certifying boards to ensure physician self-regulation.

We, the undersigned, propose a meeting of the leadership of the certifying boards, medical specialty societies, and state medical societies to discuss this crisis and plan a solution. Working together, we must create a long-term solution ensuring our professionalism and professional self-regulation. In the short term, we hope all boards will respond in a way that provides a window of opportunity. Clearly, we must show our respect for the public trust we are granted and ensure a process to maintain well-trained, highly qualified physicians. Lifelong learning and periodic assessment are valued vehicles in this process.

We propose a meeting on December 4, 2017, preceding the ABMS and CMSS dyad meeting scheduled in Chicago on December 5, 2017. This meeting will include leadership from all ABMS certifying boards, national medical specialty societies, and state medical societies. We firmly believe this is our profession's crisis and can only be solved collaboratively.

Lois, we look forward to hearing from you. We anticipate you will be sharing this letter with the CEO's of all Member Boards represented by ABMS. Please direct all responses to Hal C. Lawrence III, MD, ACOG Executive Vice President and CEO at hlawrence@acog.org or 202-863-2500.

Respectively submitted,

State Medical Societies
Medical Association of Alabama
Arizona Medical Association
Arkansas Medical Society
Connecticut State Medical Society
Medical Society of Delaware
Medical Society of District of Columbia
Florida Medical Association
Medical Association of Georgia
Hawaii Medical Association
Idaho Medical Association
Indiana State Medical Association
Iowa Medical Society
Kansas Medical Society
Kentucky Medical Association
Louisiana State Medical Society
Maine Medical Association
Medchi (The Maryland State Medical Society)
Massachusetts Medical Society
Michigan State Medical Society
Minnesota Medical Association
Mississippi State Medical Association
Missouri State Medical Association
Montana Medical Association.
Nevada State Medical Association
New Hampshire Medical Society
Medical Society of New Jersey
New Mexico Medical Society
Medical Society of the State of New York
North Carolina Medical Society
North Dakota Medical Association
Ohio State Medical Association
Oklahoma State Medical Association
Pennsylvania Medical Society
South Carolina Medical Association
South Dakota State Medical Association
Tennessee Medical Association
Utah Medical Association
Medical Society of Virginia
Washington State Medical Association
West Virginia State Medical Association
Wyoming Medical Society

National Medical Specialty Societies
American Academy of Allergy, Asthma & Immunology
American Academy of Dermatology
American Academy of Hospice and Palliative Medicine
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Orthopaedic Surgeons
American Academy of Otolaryngology-Head and Neck Surgery
American Academy of Pediatrics
American Academy of Physical Medicine and Rehabilitation
American Association of Clinical Endocrinologists
American College of Emergency Physicians
American College of Medical Genetics and Genomics
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Preventive Medicine
American College of Radiology
American College of Rheumatology
American College of Surgeons
American Epilepsy Society
American Geriatrics Society
American Psychiatric Association
American Society of Anesthesiologists
American Society of Clinical Oncology
American Society of Hematology
American Society of Nephrology
American Society of Plastic Surgeons
American Society for Reproductive Medicine
American Urological Association
College of American Pathologists
Society of Gynecologic Oncology
Society of Hospital Medicine
Society of Interventional Radiology
Society of Nuclear Medicine and Molecular Imaging

Appendix A

Maintenance of Certification

I. Concerns shared by National Medical Specialty Societies and State Medical Societies

1. Purpose of a secure exam, a summative evaluation tool vs. lifelong learning, a formative process.

2. Lack of independent data to reflect that MOC enhances quality/patient care.

3. Variation amongst different boards in MOC process and pass/fail rates.

4. Direct and indirect costs to individual physicians.

    - Exam fees to their respective certifying board, whether spread over several years or paid in one fee
    - Physician and support staff time fulfilling Part IV
    - Clinical care time and revenue loss

5. Mutation of MOC—started from a supportive place and evolved into a punitive process.

6. Perceived lack of relevance to current practice. With specialization, significant growth in data, and electronic access to research and treatment options, unlike the certifying exams given in close proximity to training, the MOC exam does not indicate real-life knowledge or assure competence.

7. Duplicative given current federal and state compliance requirements (e.g. MACRA, licensure) and other physician quality participation activities (e.g. registries, CME) as they relate to MOC Part IV.

8. Lack of transparency and communication by individual boards creating a culture gap between individual boards, medical societies and physicians.

9. MOC is a damaged brand. Threatens to undermine our professional self-regulation. MOC has the potential to damage the brands of the medical societies who may be seen as not advocating for their members who see little or no value in the current MOC program. State medical societies are being directed by a large number of their members, across multiple specialties, to introduce legislation to eliminate the use of MOC; see Appendix B.

10. Confusion between the role and authority of ABMS and role of individual boards.

11. The profession is in crisis on many fronts. Burnout among physicians is at an all-time high. Regulatory hassles, including MOC, are a primary cause of that burnout. The problems with MOC originated as an ABMS issue, but now is a medical community issue. MOC has been forced on to medical specialty and state medical societies by their members. Members are looking to their professional societies, whether specialty or state to solve the problem. The

comments are not coming from a vocal minority but rather from academic and community practice leaders.

12. The importance of professionalism and professional self-regulation is under growing attack. Using legislation that encourages legislative interference in our professional responsibilities is a very slippery slope that will gain momentum unless an acceptable solution can be found and implemented.

13. Failing to address MOC has the potential unintended consequence of attacking the certification process and returning us back to pre-Flexner time of unregulated medical practice. Hospitals and state medical licensing boards need criteria to assist in licensing and credentialing physicians.

14. Certifying Boards, National Medical Specialty Societies, and State Medical Societies must communicate and collaborate to solve the MOC crisis. There has been a lack of professional community involvement in the development and evolution of MOC and we are at a crossroad. We must work together to formulate the solution.

II. Unintended Consequences

1. MOC Activities focus on policing/compliance versus assisting physician improvement.
2. MOC being linked to licensure, employment, privileging, certification, reimbursement, etc.
3. MOC has created views that ABMS is monopolistic and not financially transparent.
4. Physicians are dropping board certification; new certifying boards are being proposed and promoted. National Medical Specialty Societies have, or are considering, eliminating board certification as a requirement for full membership.
5. The general public has been unaware of board certification; however, with increased public debate in social media/public domains, including state legislative bodies, the public may not be receiving accurate or unbiased information on board certification.
6. Professional community's feeling of being disrespected ("done to me vs. with me").

AMA AMERICAN MEDICAL ASSOCIATION

Advocacy Resource Center

Advocating on behalf of physicians and patients at the state level

Issue brief: Maintenance of Certification laws

AMA policy

H-275.924, AMA Principles on Maintenance of Certification (excerpt)

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

Maintenance of Certification and Osteopathic Continuous Certification D-275.954

34. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation[1] 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.

Key: P = Proposed; X = Signed into law

State	Licensing boards	Insurers	Hospitals	Liability insurers	Notes
Alabama					
Alaska	P	P	P		
Arizona					
Arkansas	P	P	P		
California			P		
Colorado					
Connecticut					
Delaware					
Florida	P	P	P		
Georgia (2017)	X	X*	X*	X*	OCGA 43-34-46
Hawaii					
Idaho					
Illinois					
Indiana					
Iowa					
Kansas					
Kentucky (2016)	X				KRS 311.566
Louisiana					
Maine (2017)	X	P	P		32 MRSA 2851 and 3271
Maryland (2017)	X				ACM 14-322
Massachusetts	P	P	P		
Michigan					
Minnesota					

[1] Please contact Kristin Schleiter, Kristin.schleiter@ama-assn.org, for the AMA Right to Treat Act.

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State	Licensing boards	Insurers	Hospitals	Liability insurers	Notes
Mississippi					
Missouri (2016)	X				RSMo 334.285
Montana					
Nebraska					
Nevada					
New Hampshire					
New Jersey	P	P	P		
New Mexico					
New York					
North Carolina					
North Dakota					
Ohio	P	P	P		
Oklahoma (2016)	X	X*	X*		59 OS 2011 Section 492
Oregon	P				
Pennsylvania					
Rhode Island	P				
South Carolina	P	P	P		
South Dakota					
Tennessee (2017)	X	X	X		TCA 33-2-4; TCA 63-6-2; TCA 63-9; TCA 68-11-2; TCA 56-7-10
Texas (2017)	X	X	X		Law exempts certain health care facilities and defers in some instances to the judgment of the hospital medical staff. Insurance Code F(8) Chapter 1461; Occupations Code B 151.0515, 155.003, and 156.001
Utah					
Vermont					
Virginia					
Washington					
West Virginia					
Wyoming					
TOTAL	8	4	4	1	

Updated July 2017

*Legislation incorporated in medical practice act; may not apply to insurers and hospitals.

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