OFFICE OF LEGISLATIVE RESEARCH
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ResearchReport

"Anti-Maintenance of Certification" Laws

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Issue

Provide information on (1) state laws prohibiting or limiting Maintenance of Certification (MOC) requirements for physicians (referred to as "anti-MOC" laws) and (2) the rationale for and effectiveness of "anti-MOC" laws.

Summary

MOC refers to the periodic testing and educational requirements prescribed by medical specialty boards that physicians must comply with to maintain their specialty board certifications. States that have enacted anti-MOC laws generally limit or restrict MOC requirements as a condition of (1) state licensure, (2) hospital employment and privileges, and (3) insurance reimbursement and participation in preferred provider networks.

We identified 15 states that have enacted anti-MOC laws. Six states (Arkansas, Georgia, Oklahoma, South Carolina, Tennessee, and Texas) prohibit state licensing boards, insurance providers, and hospitals from requiring physicians to maintain a specialty certification through an MOC program. An additional nine states have partial prohibitions.

States that have passed "anti-MOC" laws appear to have done so in response to physician groups' claims that, among other things, MOC requirements (1) overlap with existing state-imposed continuing medical education (CME) requirements, (2) are costly, and (3) have become essentially mandatory. Proponents, however, contend that CMEs are not uniformly rigorous enough to replace MOC requirements and, additionally, patients have an expectation that their physicians are routinely demonstrating their medical knowledge and cognitive competency.

Anti-MOC laws are relatively new. (The first state to pass an anti-MOC law, Oklahoma, did so only three years ago.) As such, we found no studies assessing their impact or effectiveness.

About MOC

Licenses to practice medicine are granted by state medical boards. Hospitals and insurance companies often require physicians to additionally obtain certification with a medical specialty board overseen by the American Board of Medical Specialists (ABMS) or American Osteopathic Association to be eligible for employment, hospital privileges, and insurance panel participation, among other benefits.

Until recently, once a physician obtained initial certification from a specialty board, he or she was certified for life. In recent years, though, specialty boards began requiring physicians (unless grandfathered-in) to take recertification exams and perform various specialty-specific activities within prescribed time periods to maintain certification (i.e., MOC requirements). For example, the American Board of Internal Medicine (ABIM) requires internists to pass a 10-hour exam every 10 years or a shorter at-home exam every two years and earn 100 credits every five years. Physicians can only earn credits by participating in specific, pre-approved activities (e.g., online courses, problem-sets, and multimedia learning modules) offered by specified providers for which they are often charged a fee. Subspecialists must meet additional requirements.

Physicians who fail the MOC recertification exam or do not complete the program's requirements face losing board certification and the benefits that come along with the certification (e.g., hospital admitting privileges) as a result.

Full and Partial State Prohibitions

Six states prohibit state licensing boards, insurance providers, and hospitals from requiring physicians to maintain a specialty certification through an MOC program (and South Carolina additionally prohibits all employers from requiring MOC as a condition of employment). Another nine states have partial prohibitions. Table 1 lists these states and briefly summarizes their laws.

Fourteen states prohibit their licensing boards from requiring physicians to participate in an MOC program. No state licensing boards had such a requirement prior to the passage of the anti-MOC laws, though. Additionally, states with such a prohibition often allow licensing boards to consider initial certification or ongoing MOC participation as a factor.

Similarly, laws that prohibit hospitals and other health care facilities from requiring MOC-compliance as a condition of granting a physician privileges or employment generally still allow

them to consider it as a factor. Additionally, North Dakota, Tennessee, and Texas carve out exceptions that allow a hospital's voting physicians to vote on whether the hospital can use MOC-compliance when making employment and privilege decisions.

Table 1: State Anti-MOC Laws

State	*Entities Prohibited From Requiring MOC Compliance*
Arizona Ariz. Rev. Stat. §§ 32-1439 & 32-1835	State licensing board
Arkansas 2019 Ark. Acts 804 (to be codified as Ark. Code Ann. §§ 17-95-413, 20-9-104 & 23-85-140)	• State licensing board • Insurance companies (for reimbursement purposes) • Hospitals (for employment or admitting privileges, except as required by medical staff bylaws or for remedial or corrective courses or training required by a quality improvement committee)
Georgia Ga. Code Ann. § 43-34-46	• State licensing board • Insurance companies (for reimbursement and malpractice coverage purposes) • State medical facilities (for employment purposes)
Kentucky Ky. Rev. Stat. Ann. § 311.566	State licensing board
Maine Me. Rev. Stat. tit. 32, § 3271	State licensing board
Maryland Md. Code Ann., Health Occ. § 14-322	State licensing board
Michigan Mich. Comp. Laws Ann. §§ 333.16147 & 500.2212d	• State licensing board • Insurance and health maintenance organizations (for reimbursement purposes; applies only to primary care pediatricians, internists, and family medicine physicians)
Missouri Mo. Ann. Stat. § 334.285	State licensing board
North Carolina N.C. Gen. Stat. Ann. §§ 90-8.1 & -13.2	State licensing board

Table 1 (continued)

State	*Entities Prohibited From Requiring MOC Compliance*
North Dakota N.D. Cent. Code Ann. §§ 23-16-18 & 26.1-47-04.1	• Insurance companies (for reimbursement and participation in provider network purposes) • Hospitals (when granting privileges and employment, with exceptions) Hospitals are exempt from the prohibition if physician MOC compliance is required for credentialing or its voting physicians vote to allow it to differentiate between physicians based on MOC compliance
Oklahoma Okla. Stat. Ann. tit. 59, § 492	• State licensing board • Insurance companies (for reimbursement purposes) • Hospitals (when granting admitting privileges and employment)
South Carolina S.C. Code Ann. § 40-47-38	• State licensing board • Insurance companies (for reimbursement purposes) • Employers • Hospitals (when granting admitting privileges and employment)
Tennessee Tenn. Code Ann. §§ 33-2-422, 56-7-1006, 63-9-123, 63-6-246 & 68-11-242	• State licensing board • Insurance companies (for reimbursement and participation in provider networks purposes) • Hospitals and certain health care facilities (when granting privileges and employment, with exceptions) Hospitals and health care facilities are exempt from the prohibition if physician MOC compliance is required for facility credentialing or if its voting physicians vote to allow the hospital or facility to differentiate between physicians based on MOC compliance
Texas Tex. Ins. Code Ann. § 1461; Tex. Occ. Code Ann. §§ 155.003 & 151.0515	• State licensing board • Insurance companies and related entities, such as HMOs (for the purposes of payment, reimbursement, and contracting to provide services, with exceptions) • Most hospitals and health care facilities (with exceptions, cannot differentiate between physicians based on MOC compliance) The following entities are exempt from the prohibition: (1) medical schools, (2) comprehensive cancer centers, and (3) hospitals and health care facilities if physician MOC compliance is required for credentialing or its voting physicians vote to allow it to differentiate between physicians based on their MOC compliance
Washington Wash. Rev. Code Ann. §§ 18.57.083 & 18.71.083	State licensing board, with certain exceptions

Arguments For and Against MOC Requirements

States that have passed anti-MOC laws appear to have done so in response to physician-advocacy group assertions that, among other things, MOC requirements are (1) duplicative of state mandated CME requirements, (2) costly, and (3) de facto mandates for physicians.

Proponents of MOC requirements assert, among other things, that CMEs are not sufficient to replace MOC learning requirements and maintain that patients expect their physicians to regularly demonstrate their competency to an evaluative body.

Overlap with State Licensing CME Requirements

Most states require physicians to annually earn a number of CME credits to maintain their state licenses to practice medicine. According to the organization that accredits CME providers, CME consists of "educational activities which serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public, or the profession." Some MOC critics argue that the CME requirements serve the same purpose as MOC credits and are preferable to board-selected MOC offerings because they allow physicians to select from a variety of courses provided by many different healthcare-related entities.

In Connecticut, for example, physicians applying for license renewal must generally show they have performed at least 50 hours of CME activities during the preceding two years. To qualify, the activities must (1) be in a physician's practice area; (2) reflect the professional needs of the licensee in order to meet the health care needs of the public; and, (3) every six years, include training on specified topics (e.g., infectious diseases, sexual assault, and domestic violence). CME courses may be provided or approved by a number of healthcare-related entities, such as the American Medical Association, Connecticut Hospital Association, hospitals, and county medical societies (CGS § 20-10b).

On the other hand, ABMS cites physicians' latitude in course selection as a reason CMEs are not a reasonable substitute for MOC credits. "[CME] activities are variable in quality…Research has shown that individuals have limited ability to self-assess their gaps in knowledge and skills to identify their learning and improvement needs. In combination with challenges in self-assessment, self-selected CME activities are insufficient to ensure [certified physicians] remain up-to-date in clinical practice." (ABMS, *Continuing Board Certification: Vision for the Future*, ix (2019)).

Cost

According to a 2015 study, ABIM-certified internists incur an average of $23,607 in MOC costs over 10 years to maintain their certification, ranging from $16,725 for general internists to $40,495 for hematologists-oncologists. Time (i.e., time spent not treating patients) accounted for 90% of the costs. Annual fees to ABIM, testing fees, and access to online ABIM modules accounted for the other 10% of the costs.

Mandatory in Practice

Specialty board certification is voluntary and no states require certification as a condition of licensure to practice medicine. However, physicians may be required by employers and insurance companies to obtain specialty board certification. According to the Texas Medical Association's testimony regarding Texas's anti-MOC legislation, for example, physicians expressed concerns that the use of MOC by insurers and certain health care facilities served as a "de facto mandate on physicians."

Patient Expectations

MOC proponents assert that patients expect that their physicians are regularly demonstrating their competency and rely on certification as an indicator of physician expertise. According to one survey, 95% of respondents said it is important that their physician participate in the MOC process, described as "a process by which doctors who are Board Certified continue to participate in a continuous process of lifelong learning and self-assessment in their specialties." In the same survey, 78% of respondents said they would be bothered if their doctor chose not to maintain his or her certification.

In a 2016 research study, the physician authors state that "MOC is the public's assurance that a physician is engaged in continuous professional development, especially now—as systems of care become more complex and medical knowledge and technology advance at unprecedented rates" ("The ABMS MOC Part III Examination: Value, Concerns, and Alternative Formats," *Academic Medicine*, vol. 91, no.11, November 2016).

Demonstration of Competency

Generally physicians do not need to retake exams or undergo ongoing testing to maintain their state licenses to practice medicine. And advocates of keeping MOC testing requirements often assert that the initial specialty certification exam is insufficient to ensure physicians maintain their cognitive abilities and knowledge of current medical practices throughout their careers. According to one study, evidence suggests that there is an inverse relationship between the number of years

that a physician has been in practice and the quality of care that the physician provides ("Systematic Review: The Relationship between Clinical Experience and Quality of Health Care," *Improving Patient Care*, vol. 142, no. 4, February 2005).

MOC's periodic examinations are seen by some as providing an unbiased check that evaluates the knowledge base, diagnostic reasoning, and clinical judgment expected of the physician in the broad domain of his or her discipline and, to a certain extent, a physician's cognitive abilities.

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