MOC Advocacy Talking Points

- “Maintenance of Certification” requirements on board certified physicians are called “MOC.” MOC is comprised of computer modules, formal testing, and other activities that have little or no perceived value with respect to quality improvement or competency among the provider community. There are no independent medical studies or evidence demonstrating the value of MOC in terms of improved patient outcomes. Instead, it is overly burdensome, costs physicians thousands of dollars, and ironically, requires significant time away from practicing medicine and taking care of patients. ACG believes the time is long-overdue for fundamental changes to MOC, thus the need to be very active at the state level. Fortunately ACG’s Board of Governors is structured to help meet the demands of membership at the state and local level. As this timeline below demonstrates, ACG and specialty societies have tried with the ABIM on numerous occasions throughout the year to improve MOC. ACG is still committed to working with ABIM to make this process on life-long learning rather than testing. The College continues to stand firm in its fundamental commitment to push ABIM to re-envision and overhaul the MOC process.

- According to the American Board of Internal Medicine (ABIM) in December 2016, “despite critics’ claims to the contrary, we believe the evidence is convincing, albeit incomplete, that certain outcomes are better for patients treated by board-certified physicians. Published data show, for example, that the risk of both death and emergency coronary artery bypass grafting is lower when patients undergoing percutaneous coronary interventions are treated by board-certified interventional cardiologists, and the cost of care for Medicare beneficiaries is 2.5% lower among physicians who were obliged to complete MOC than among those who were not. Because the vast majority of physicians are board-certified, certification can easily be taken for granted. But in an Internet-based world where anyone can become, for example, an ordained minister online, reliable credentials based on solid standards have become even more valuable.” *N Engl J Med* 2016; 375:2516-2517

- In a study published prior to the December 2016 article, “although the ABIM argues that there is evidence supporting the value of MOC, high-quality data supporting the efficacy of the program will be very hard, if not impossible, to obtain. In fact, close examination of the reports cited by the ABIM reveals that the data are ambiguous at best: in a meta-analysis of 33 studies, 16 described a significant association between certification status and positive clinical outcomes, 14 found no association, and 3 found a negative association. Moreover, the authors of the meta-analysis concluded that the research methods of most published studies on this topic are inadequate. Almost all published studies evaluate initial board certification, not recertification or MOC, and the rigorous requirements for initial certification should not be equated with the busywork required for the MOC every 2 years. One of the few studies examining lapsed certification showed no effect of physicians’ certification status on patient outcomes after
coronary intervention. Two very recent studies found no association between recertification and performance or quality measures; one, conducted by ABIM members, found a minor reduction in cost of care. No study provided level-A data, and these findings relate only to recertification, not the controversial new MOC requirements.”  


• An October, 2016 article in the Mayo Clinic Proceedings concluded that only 24 percent of physicians agreed that MOC activities are relevant to their patients, only 15 percent thought they were worth the time and effort, and 81 percent believed that they were a burden. These results were “pervasive, and not localized to specific sectors or specialties.”

• Internists will incur an average of $23,607 (95% CI, $5,380 to $66,383) 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. Cumulatively, 2015 MOC will cost $5.7 billion over 10 years, $1.2 billion more than 2013 MOC. This includes $5.1 billion in time costs (resulting from 32.7 million physician-hours spent on MOC) and $561 million in testing costs. The ABIM MOC program will generate considerable costs, predominantly due to demands on physician time. A rigorous evaluation of its effect on clinical and economic outcomes is warranted to balance potential gains in health care quality and efficiency against the high costs identified in this study.


Timeline of Events

2014: In January 2014, the American Board of Internal Medicine (ABIM) changed its certification policies for physicians. Instead of being listed by the ABIM as “certified,” physicians are now listed as “certified, meeting maintenance of certification (MOC) requirements” or “certified, not meeting MOC requirements.” MOC requirements include ongoing engagement in various medical knowledge, practice-assessment, and patient-safety activities, on which physicians are assessed every 2 years, and passage of a secure exam in one's specialty every 10 years.

February 2015: Richard Baron, President and CEO of ABIM in an honorable move, apologized to ABIM diplomats stating “We got it wrong and sincerely apologize...We launched programs that weren’t ready and we didn’t deliver a MOC program that physicians found meaningful...and...we want to change that.” In addition – ABIM is updating the Internal Medicine MOC exam to focus on making the exam more reflective of what physicians in practice are doing.

November 2015: In a letter to ABIM’s President, Dr. Richard Baron, on November 6, 2015, and in subsequent conversations and communications, the College raises significant concerns that the ABIM MOC program is largely duplicative, time consuming and expensive. The College questioned the relevance of the MOC program overall, as well as the unacceptable – and at times clinically irrelevant – content of the recertification exam.

March 2016: ACG President-elect Dr. Carol A. Burke attends meeting with the ABIM senior leadership team, including Richard Baron, MD, Richard Battaglia, MD, ABIM’s Chief Medical Officer, as well as members of the ABIM Gastroenterology Board. The meeting was an opportunity to represent the ACG membership and voice their concerns about the current status of MOC and reiterate ACG’s position with ABIM leaders.
April 2016: ACG signs on to a joint communication to ABIM along with the GI societies and nine other specialty groups requesting a better understanding of ABIM’s plan for re-engineering MOC to reflect the changing nature of medical practice.

May 2016: ABIM makes announcement on changes to MOC but accepts little input from ACG and other societies.

September 2016: ACG President Dr. Kenneth R. DeVault travels to Philadelphia to attend a meeting convened by ACP and AAIM with representatives from ABIM. Dr. DeVault reaffirmed the College’s commitment to the principles that MOC be must be simpler, less intrusive, and less expensive.

ACG’s representative to ABIM’s Liaison Committee on Certification and Re-Certification (LCCR), Dr. Michael S. Smith, also attends a meeting hosted by ABIM at which alternative MOC assessment models structured for either 2-or 5-year intervals were on the agenda. ACG joined more than 20 other internal medicine societies in unanimous criticism of ABIM’s plans.

October 2016: ABIM convenes “Listening Sessions” to open community dialogue between gastroenterologists and the ABIM regarding MOC, including sessions at the ACG Annual Scientific Meeting in Las Vegas. Attendees reported that the sessions were not a dialogue, but were only meant to drive diplomates to choose their preference for either a two- or five-year, high stakes, MOC exam. They felt that ABIM only paid lip service to openness to discussion.

2017: ABIM and ABMS advocating around the country, opposing state bills limiting the grip MOC has on physician employment, hospital privileges and contracts with payors. Among the rationale for opposing anti-MOC legislation around the country include: these bills inhibit the right of hospitals and facilities to contract with physicians as they see fit, MOC continues to be a measurement of competence and quality of care for facilities to help ensure they employ/contract with physicians, and MOC is continual education (not continual testing).

March 2017: ABIM makes announcement on MOC changes, but in spite of consistent and widespread pressure, ABIM has not made meaningful changes to MOC. The College has participated in and facilitated opportunities for exchange with the ABIM, seemingly to no avail. Against the backdrop of increasingly negative perceptions of MOC, ABIM is still getting it wrong.