Ohio CHAPTER

Issues from the ACC: What Is Impacting CV Providers in 2018

Rick Chazal, MD, MACC
Past President, ACC
Medical Director, Heart and Vascular Institute
Lee Health, Florida

October 27, 2018

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Disclosures

- None

ACC in One Slide…

Mission:

To transform cardiovascular care and improve heart health

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Vision:

A world where innovation and knowledge optimize cardiovascular care and outcomes

In every decision ACC is

Patient-Centered

We are stronger through

Teamwork & Collaboration

We strive for

Professionalism & Excellence

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ACC by the Numbers

54,000+ members across the entire cardiovascular care team

More than 85 percent of U.S. cardiologists are ACC members

48 Domestic Chapters

42 International Chapters

10 NCDR Registries

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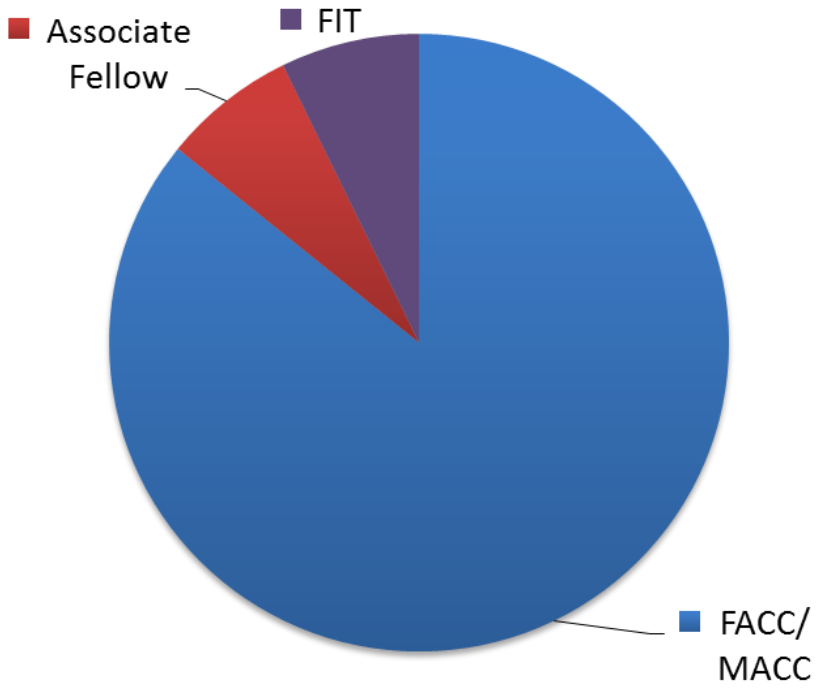
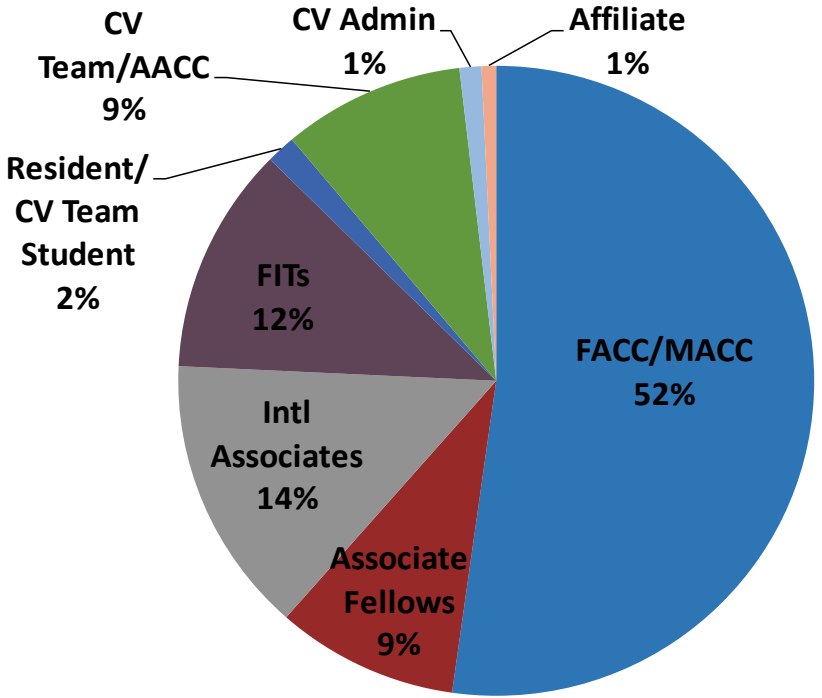
ACC in 2000 (26,000 Members)



ACC in 2018 (54,000 Members)



Source (Right): *Data compiled from* ***2017*** *Year End Official Member Count*

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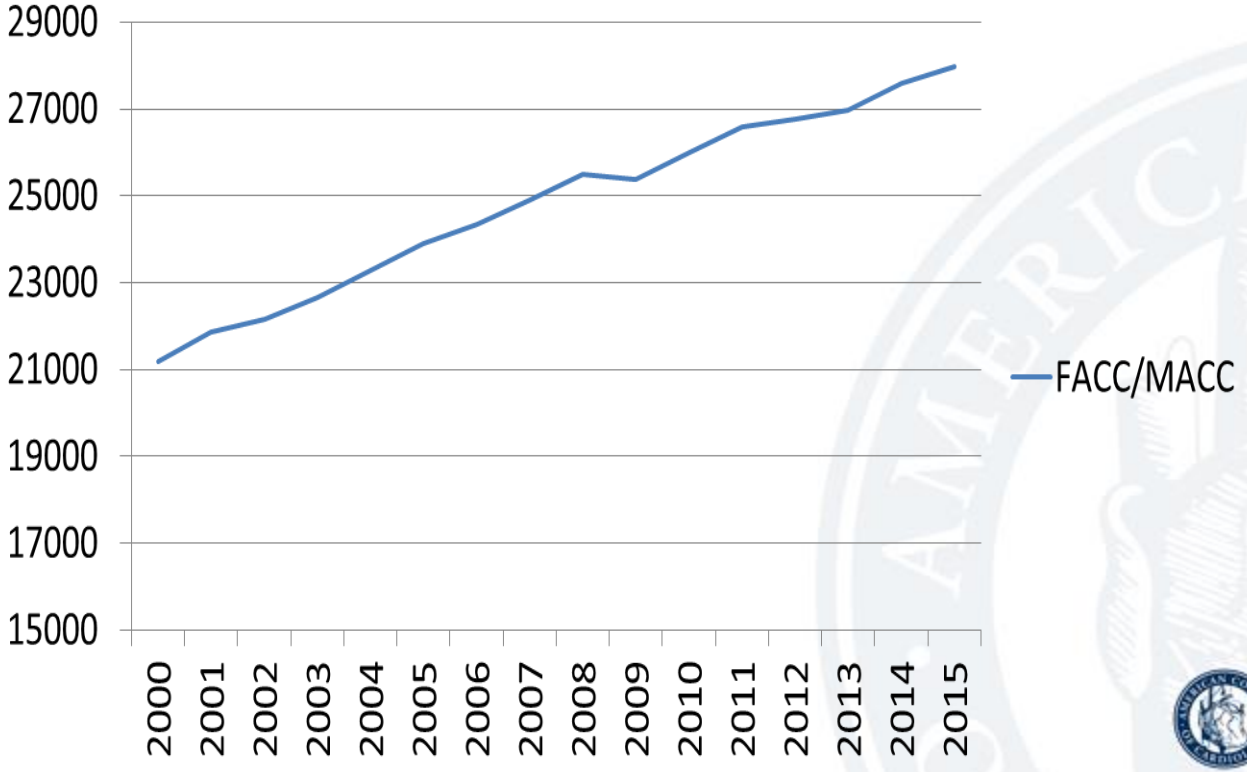
Growth of *FACC/MACC* Members Since 2000



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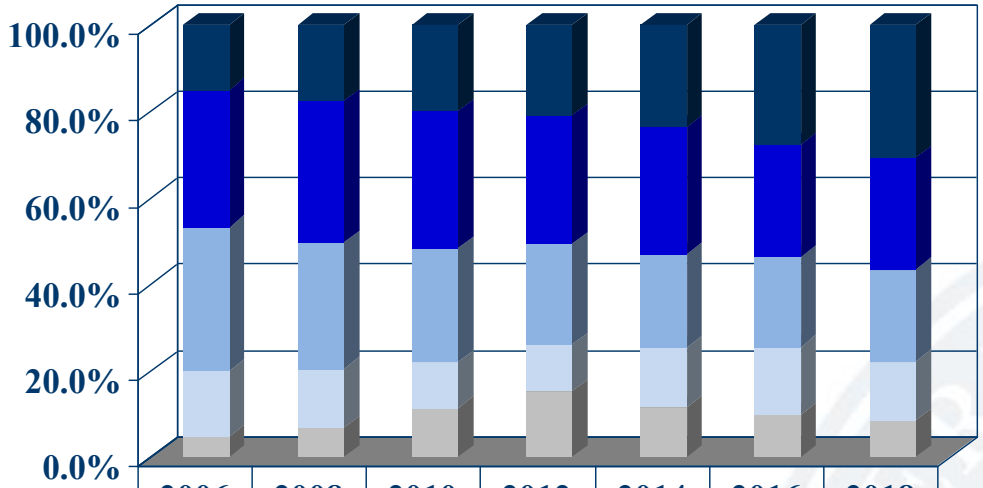
U.S. Physician Age Trends (Excluding FIT and Emeritus)



	2006	2008	2010	2012	2014	2016	2018
61 and Over	14.9%	17.6%	19.9%	20.8%	23.7%	27.7%	30.7%
51-60	31.8%	32.8%	31.8%	29.8%	29.2%	26.1%	25.9%
41-50	33.2%	29.2%	26.4%	23.4%	21.8%	20.8%	21.3%
Under 40	15.3%	13.7%	10.6%	10.9%	13.7%	15.6%	13.6%
Unknown	4.7%	6.7%	11.3%	15.1%	11.6%	9.9%	8.5%
Average Age:	50.6	51.6	52.8	53.1	53.1	53.4	54.4

Includes AA, AF, FF, MA Member Types

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Fiscal and Staff Growth in the Last Quarter Century (1990 – 2018)

1990 Highlights

Members: 18,700

FTEs: 80+

Operations Revenue: $18.3M

Investments: $19.4M

Total Net Assets: $28.8M

Debt: $0

2018 Highlights

Members: 54,000+

FTEs: 525+

Operations Revenue: $140M

Investments: $120M

Total Net Assets: $87.3M

Debt: $60.9M

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ISSUES…and working toward solutions

- Burnout
- MACRA, QPP, MIPS, ACO's, CMS rules…
- Employment, contracts, wRVU's, volume to value…
- MOC
- Strategic Plan
- Advocacy: Behind the Scenes
- Innovation
- Diversity
- CMP

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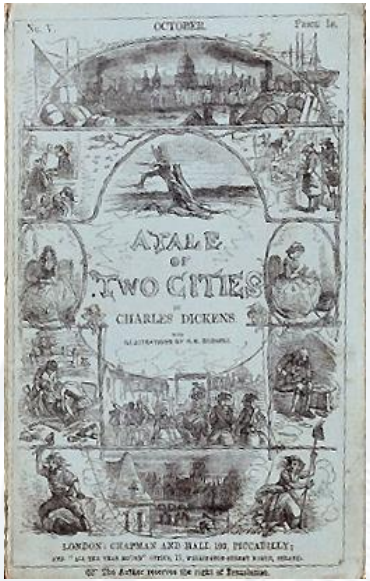
The Health Care Environment 2018

Cardiovascular Care 2018

"It was the best of times, it was the worst of times …"

…it was the age of wisdom, it was the age of foolishness, it was the epoch of belief, it was the epoch of incredulity, it was the season of Light, it was the season of Darkness, it was the spring of hope, it was the winter of despair, we had everything before us, we had nothing before us, we were all going direct to Heaven, we were all going direct the other way …



Charles Dickens – 1859
"A Tale of Two Cities"

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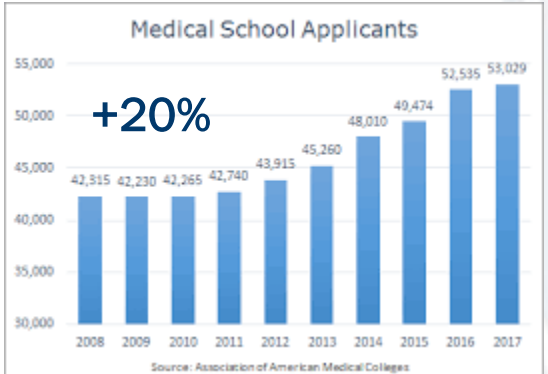
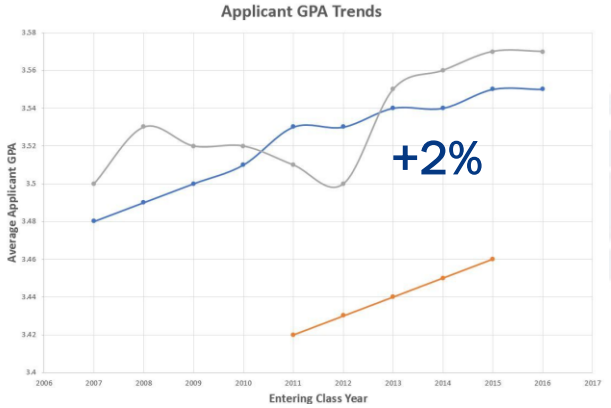
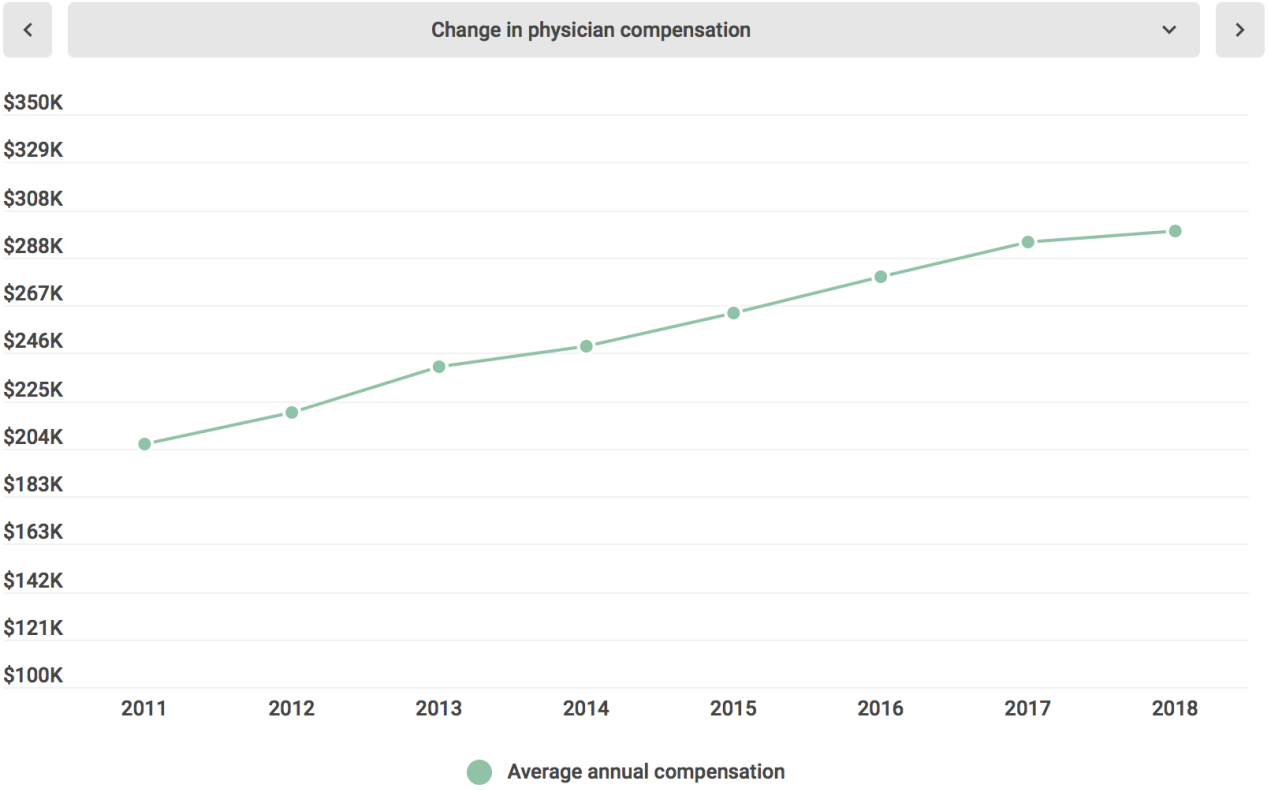
Cardiovascular Care 2018

- **Best of Times**
- Declining CV mortality/morbidity
- Basic and clinical research
- Innovation
- Big data
- Precision medicine
- Talent
- Finances





Change in Compensation Over Time



Note: CEO/CFO compensation is an average of the CEO/CFO salaries at the 22 hospitals on US News & World Report's 2017 Honor Roll List

Source: Medscape 2018 Physician Compensation Report; The Growing Executive-Physician Wage Gap in Major US Nonprofit Hospitals.

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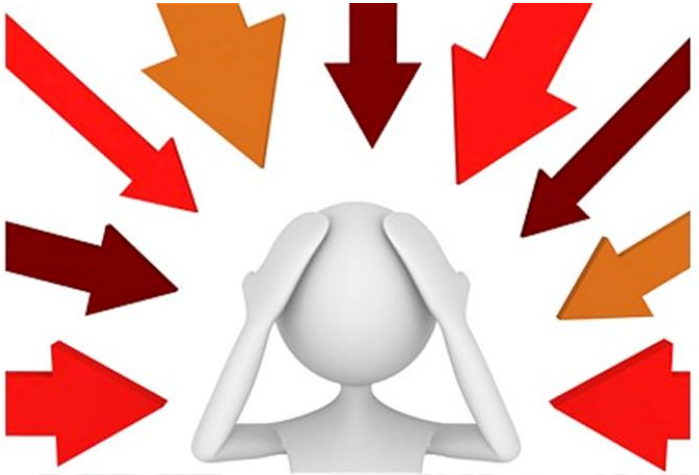
Worst of Times

- Regulation and Compliance
- Pressures to Reduce Cost
- Rapidity of Change
- Time Pressure
- Distractions from Care of the Patient
- Work Related Stress
- Employment
- EHR



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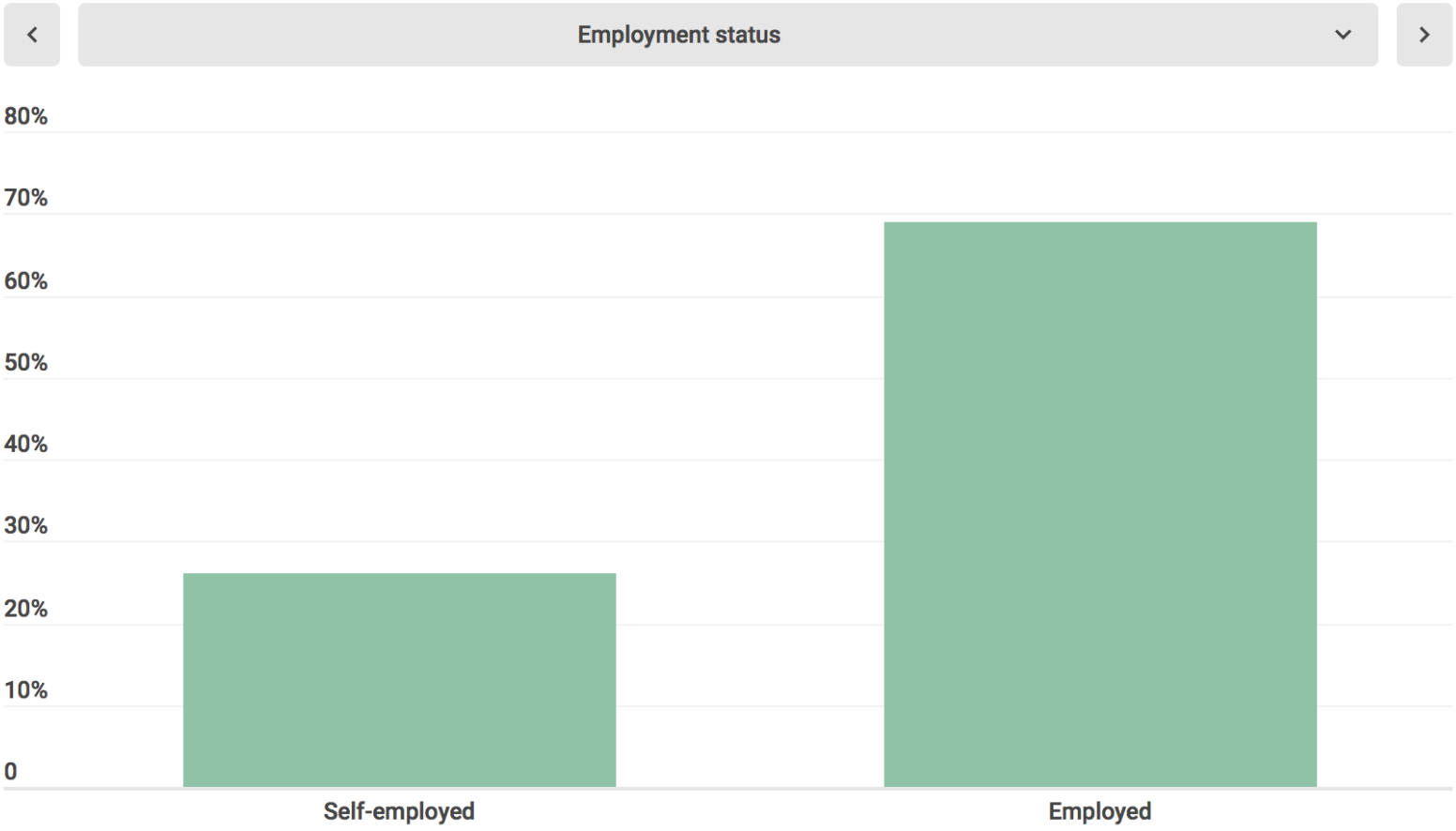
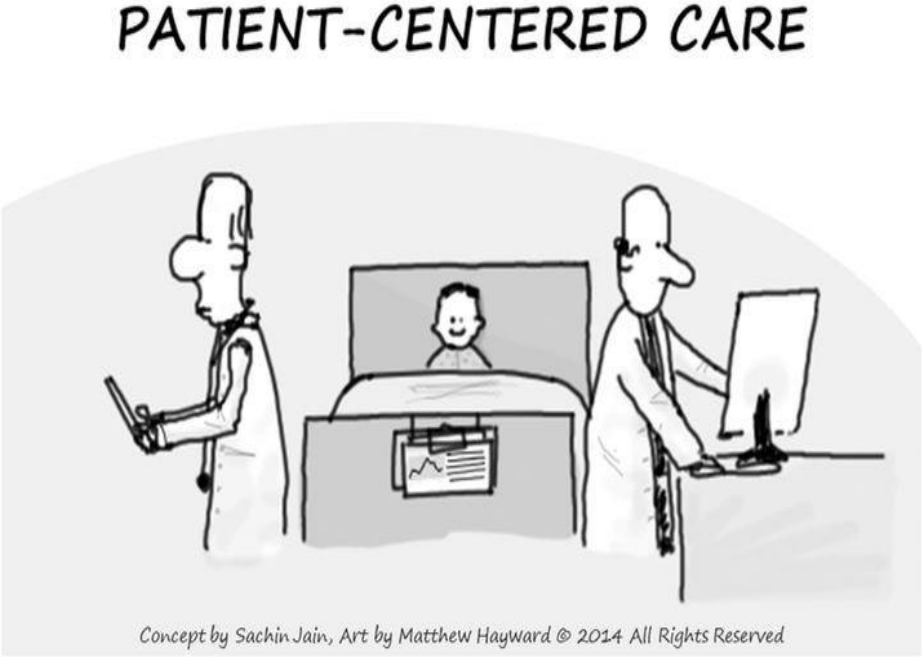


Source: Medscape 2018 Physician Compensation Report

State of Our Patients



What's Making Patients Unhappy?

#1 Complaint: Customer Service
#2 Complaint: Poor Communication

Other Complaints:

- Billing Issues
- Difficulty Getting Appointments
- Too Rushed During Office Visits
- Inconvenient Hours
- Too Many Forms
- Cost of Medications
- Doctor Is Too Busy on EHR/Device

TABLE 2

Domains of dissatisfaction and corresponding implicit expectations

Domains of Dissatisfaction	Implicit Expectations	Example
Ineptitude	Safety	The only thing was that when I was getting ready to get discharged, one of Dr. H*'s associates came in and said, "We have to readmit you for a further procedure." I said, "Well, that's strange because Dr. H* put in a stent yesterday, and I'm supposed to leave today." Well, he checked, and he had the wrong guy. I'm glad I said something or else they probably would have hauled me off.
Disrespect	Treatment with Respect and Dignity	Transport was rude due to me being a heavy person. They were saying they didn't want to move me and snickering.
Prolonged Waits	Prompt and Efficient Care	I called for someone because I had to use the bathroom really bad, but I had those things stuck to my legs and needed help walking to the bathroom but no one came. Well, I had to go so bad that I had a panic attack. Then all these people came rushing in to help. I felt so embarrassed.
Ineffective Communication	Successful Exchange of Information	There were a few days that [were] a little confusing to me. I didn't know if I was going to have surgery or go home. The communication wasn't that great.
Lack of Environmental Control	Environmental Autonomy and Control	I was put in a room with a man who had many issues. He was loud and yelling all night. It was a very disturbing experience.
Substandard Amenities	High Quality Amenities	In that ICU they should put a TV on the ceiling for when you're lying flat on your back looking at the ceiling tiles for 4 days.

Lee AV, Moriarty JP, Borgstrom C, Horwitz LI. What can we learn from patient dissatisfaction? Analysis of dissatisfying events at an academic medical center. Journal of hospital medicine : an official publication of the Society of Hospital Medicine. 2010;5(9):514-520. doi:10.1002/jhm.861.

Research From: Journal of Medical Practice Management; Becker's Hospital Review; Consumer Reports

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Annals of Internal Medicine

ORIGINAL RESEARCH

Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties

Christine Sinsky, MD; Lacey Colligan, MD; Ling Li, PhD; Mirela Prgomet, PhD; Sam Reynolds, MBA; Lindsey Goeders, MBA; Johanna Westbrook, PhD; Michael Tutty, PhD; and George Blike, MD

Background: Little is known about how physician time is allocated in ambulatory care.

Objective: To describe how physician time is spent in ambulatory practice.

Design: Quantitative direct observational time and motion study (during office hours) and self-reported diary (after hours).

Setting: U.S. ambulatory care in 4 specialties in 4 states (Illinois, New Hampshire, Virginia, and Washington).

Participants: 57 U.S. physicians in family medicine, internal medicine, cardiology, and orthopedics who were observed for 430 hours, 21 of whom also completed after-hours diaries.

Measurements: Proportions of time spent on 4 activities (direct clinical face time, electronic health record [EHR] and desk work, administrative tasks, and other tasks) and self-reported after-hours work.

Results: During the office day, physicians spent 27.0% of their total time on direct clinical face time with patients and 49.2% of their time on EHR and desk work. While in the examination room with patients, physicians spent 52.9% of the time on direct clinical face time and 37.0% on EHR and desk work. The 21 physicians who completed after-hours diaries reported 1 to 2 hours of after-hours work each night, devoted mostly to EHR tasks.

Limitations: Data were gathered in self-selected, high-performing practices and may not be generalizable to other settings. The descriptive study design did not support formal statistical comparisons by physician and practice characteristics.

Conclusion: For every hour physicians provide direct clinical face time to patients, nearly 2 additional hours is spent on EHR and desk work within the clinic day. Outside office hours, physicians spend another 1 to 2 hours of personal time each night doing additional computer and other clerical work.

Primary Funding Source: American Medical Association.

Ann Intern Med. 2016;165:753-760. doi:10.7326/M16-0961 **www.annals.org**
For author affiliations, see end of text.
This article was published at www.annals.org on 6 September 2016.

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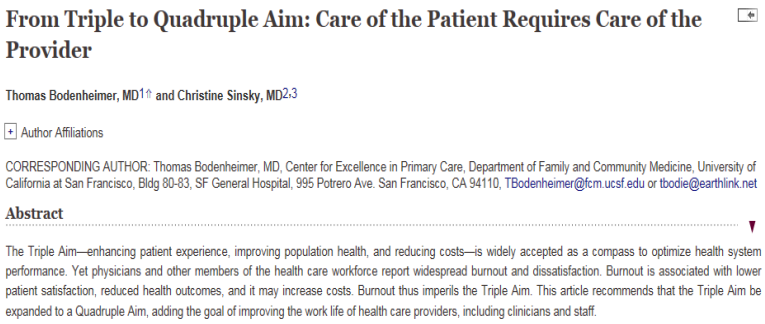
State of Our Members

What's Missing From the Triple Aim of Health Care?

It's time to prioritize worker satisfaction, along with the aims of patient experience, population health, and cost reduction.

BY LARRY SOBAL, MBA, MHA, CMPE, AND SUZETTE JASKIE



From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider

Thomas Bodenheimer, MD[1] and Christine Sinsky, MD[2,3]

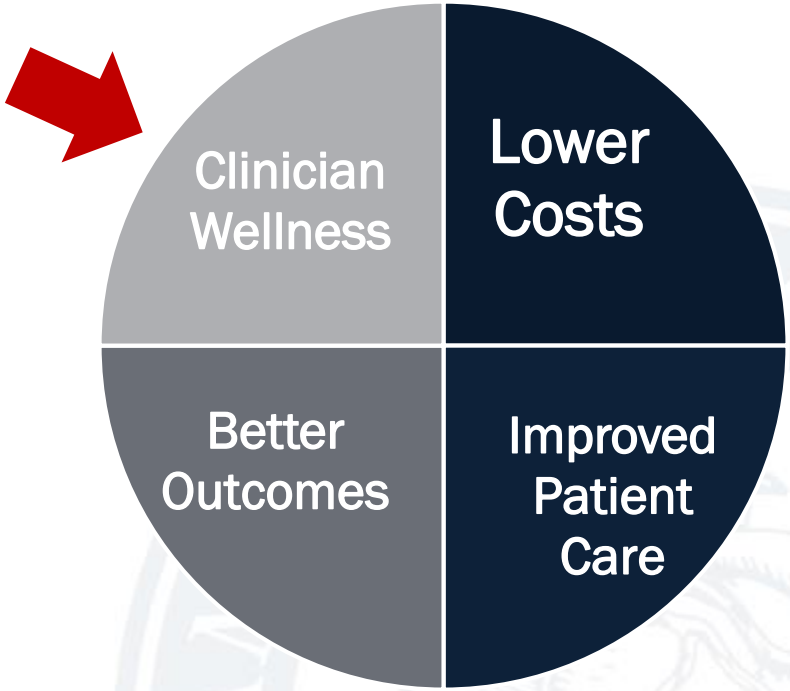
Author Affiliations

CORRESPONDING AUTHOR: Thomas Bodenheimer, MD, Center for Excellence in Primary Care, Department of Family and Community Medicine, University of California at San Francisco, Bldg 80-83, SF General Hospital, 995 Potrero Ave. San Francisco, CA 94110, TBodenheimer@fcm.ucsf.edu or tbodie@earthlink.net

Abstract

The Triple Aim—enhancing patient experience, improving population health, and reducing costs—is widely accepted as a compass to optimize health system performance. Yet physicians and other members of the health care workforce report widespread burnout and dissatisfaction. Burnout is associated with lower patient satisfaction, reduced health outcomes, and it may increase costs. Burnout thus imperils the Triple Aim. This article recommends that the Triple Aim be expanded to a Quadruple Aim, adding the goal of improving the work life of health care providers, including clinicians and staff.

The Quadruple Aim Imperative



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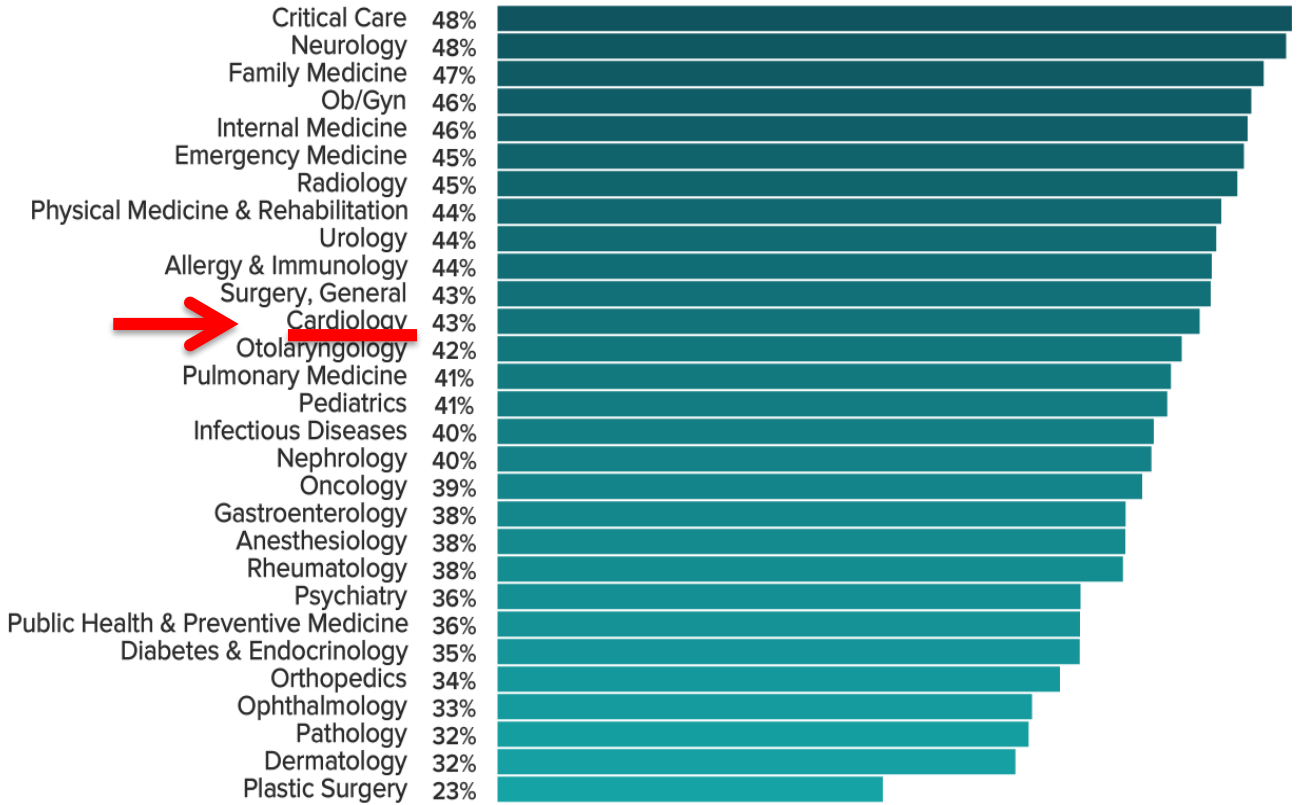
Which Physicians Are Most Burned Out?



4 out of 10 Cardiologists are “Burned-Out”

Source: Medscape Physician and Depression Survey 2018

What Contributes to Physicians' Burnout?

Biggest “Pain Points”:

- Compliance
- Inefficiency, time

Source: Medscape Physician and Depression Survey 2018

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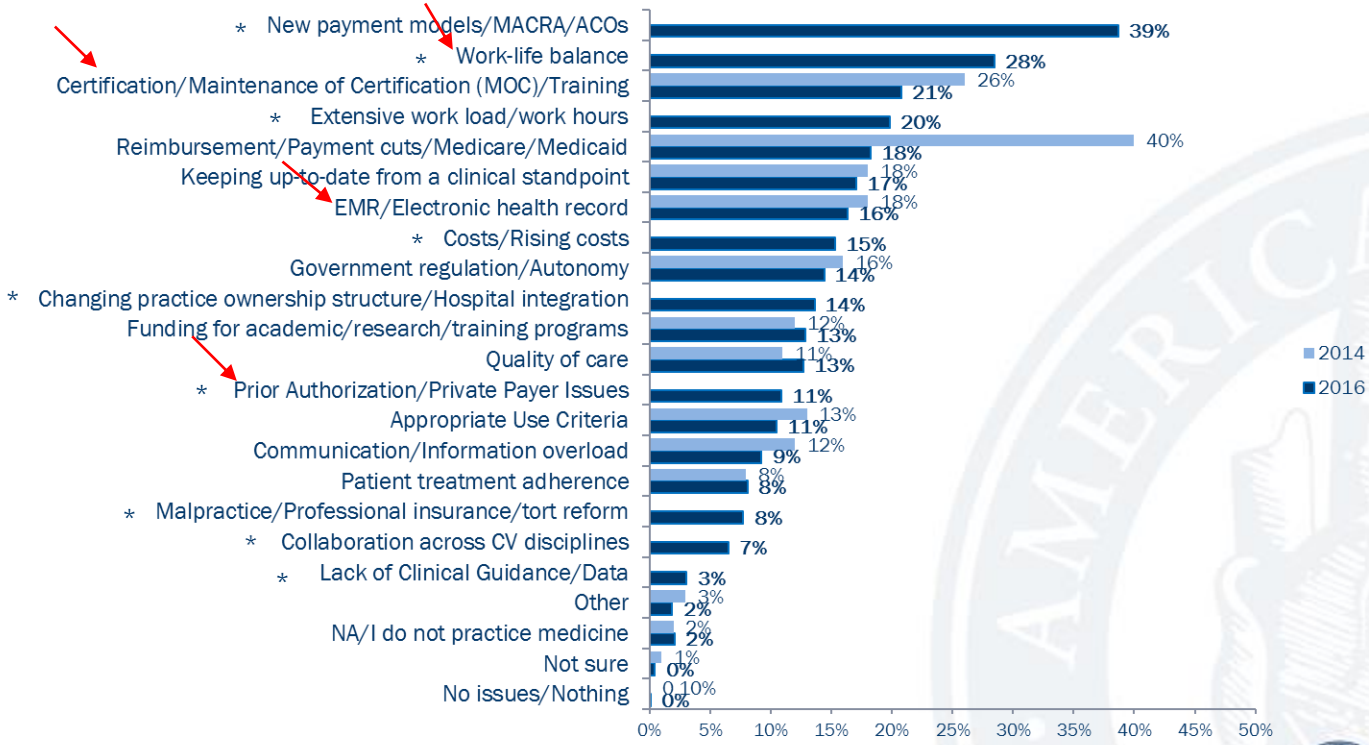
Biggest Challenges in CV Medicine

- Payment issues/new models continues to be a challenge in CV medicine. Two fifths (39%) of members identify new payment models/MACRA/ACOs as the biggest issue facing CV medicine. Work-life balance (28%), certification/MOC (21%), and extensive work load/work hours (20%) are also challenges



* New category added in 2016

Q: *What are the three biggest issues you will face in cardiovascular medicine over the next three years?*

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Quality patient care relies on the health and wellness of the individuals – physicians and care team members – providing that care.

Balance is critical.

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This great new process will improve patient care. It's only a few extra clicks in your EHR...

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Here's something else that will improve patient care. Won't add too much time to workflow…

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Patient care will really benefit if we do this and it just adds a little more to the process for you…

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We know this is extra work but it truly benefits patients…

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This shouldn't take too much extra energy…

Physician Wellness

Quality Patient Care

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Our processes are quick since everything is digital. This shouldn't be too much for you…just a few clicks…

Physician Wellness

Quality Patient Care

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It's just a few extra clicks...really...

Physician Wellness

Quality Patient Care

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Wait a second…something isn't working here…

Physician Wellness

Quality Patient Care

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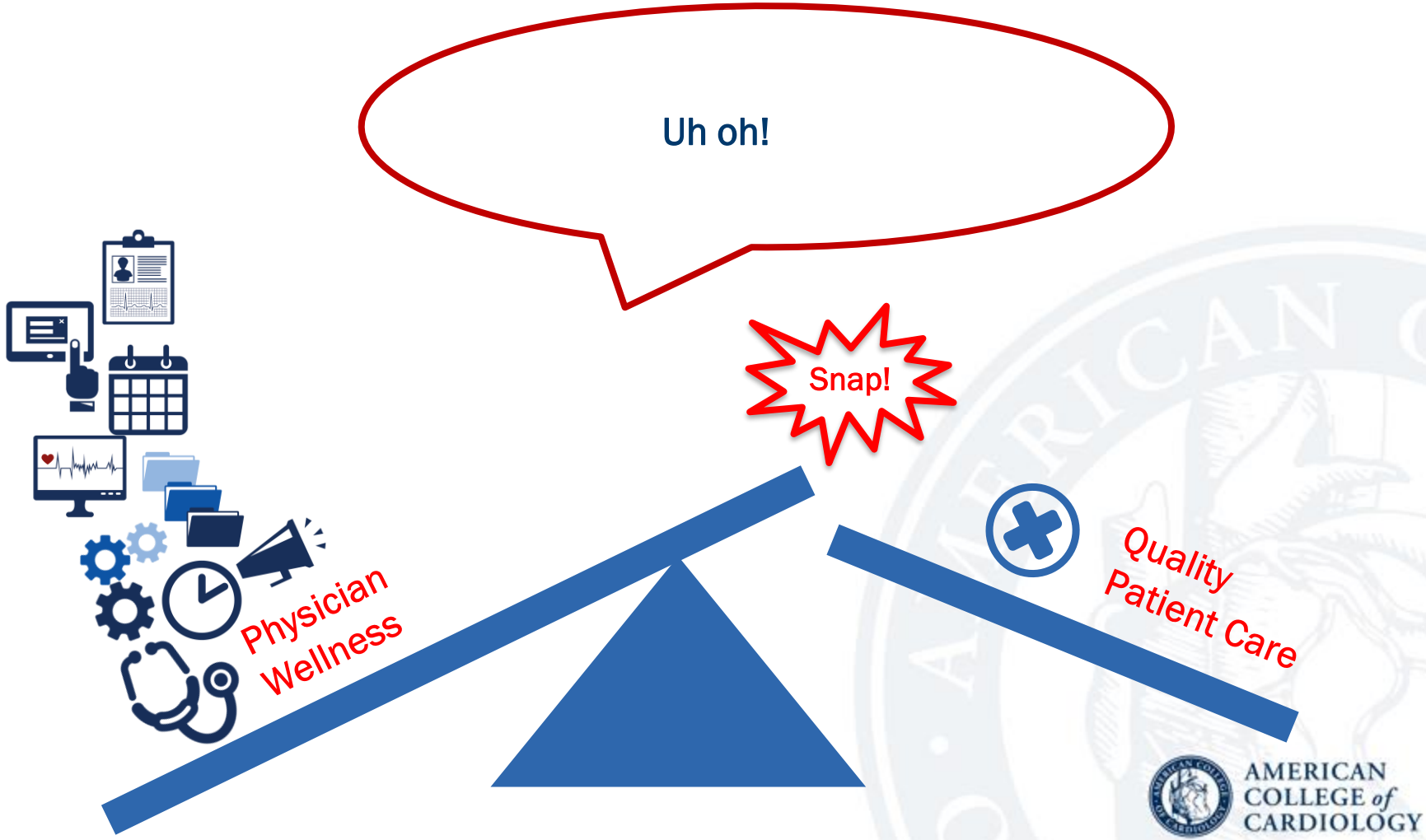

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"So, ACC… What Have You Done for Me Lately?"

- New Strategic Plan
- Behind the Scenes Advocacy
- Innovation
- Diversity and Inclusion
- ABIM/MOC

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High-Level Strategic Plan

Mission Statement	Vision Statement	Core Values
To transform cardiovascular care and improve heart health.	A world where innovation and knowledge optimize cardiovascular care and outcomes	Patient-Centered Teamwork & Collaboration Professionalism & Excellence

Goal 1: Increase relevance as the CV professional home

Focus Areas:

- Member recruitment, retention, and engagement
- Membership diversity and inclusion
- Promotion of member well-being
- Health systems and organizational engagement

Goal 2: Generate and deliver actionable knowledge

Focus Areas:

- Timely creation of consumable knowledge sources
- Utilization of consumable knowledge sources

Goal 3: Advance quality, equity, and value of CV care

Focus Areas:

- Adoption of ACC solutions and tools
- Reduction of variations and disparities in care
- Support members to assess and improve value of care

Goal 4: Ensure organizational growth and sustainability

Focus Areas:

- Create innovative projects to drive the mission of ACC
- Enhance organizational efficiency
- Invest in future leadership (members and staff)

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Reduce Members' Administrative & Professional Burdens

Description: Increasing administrative and professional burdens are taking caregivers away from what they do best – providing care. These pressures are leading to clinician burnout, increasing overhead costs, and impacting the appeal of cardiology as a career field. The initiatives related to this priority aim to address particular challenges with regulations, EHR usability and interoperability, quality reporting, payment transformation, MOC, and data collection.

2018 Initiatives Category	Proposed Strategic Initiatives / Projects Submitted by Committees and Staff To be tracked on the Enterprise Strategic Dashboard	
Clinician Wellbeing	1	Advocate for reduced administrative burdens, including prior authorization, electronic health record usability and interoperability, and improved consistency/validity of quality measures and reporting
	1	Advocate for and educate members on changes in payment, including MACRA/QPP and alternative payment models
		Launch working group to determine path forward on non-clinical best practices, CV team management, and clinician well-being
Maintenance of Certification	2	Support maintenance of CV certification for physician members
	3	Further expansion of CME/MOC offerings on JACC.org
		Continue negotiations with ABIM on Society Maintenance Pathway
Reduce Data Burden	4	Continue efforts to reduce participant data collection burden by enhancing NCDR's integration with EHRs and other electronic data sources

Direct input from Member Committees: (1) Health Affairs, (2) LLOC, (3) PECC, (4) NCDR MB

Advocacy Update: ACC in Action

ACC sent 17 Congressional Letters in 2016

Comment Letters

- Senate Finance Committee - Improving Care for Individuals with Chronic Disease (1/16)
- Senate Finance Committee - Stark Law Principles (1/16)
- Senate HELP Committee - Bipartisan Health IT Discussion Draft (1/16)
- House Energy and Commerce Committee – Site-Neutral Payment Policy Clarification (2/16)

Letters of Support

- H.R. 3355/S. 488 – A bill that would allow PAs, NPs, and clinical nurse specialists to supervise cardiac, intensive cardiac, and pulmonary rehabilitation programs (2/15)
- H.R. 3952/S. 2248 – Congenital Heart Futures Act (11/15)
- H.R. 546/S. 298 – Advancing Care for Exceptional (ACE) Kids Act (1/15)
- S. 2141 – TRUST IT Act of 2015 (1/16)
- H.R. 5001/S.2822 – Flexibility in EHR Reporting Act (4/16)

Letter of Opposition

- H.R. 5088 – Promoting Integrity in Medicare Act – (bill opposing removing the IOASE exception to the Stark law) – (5/16)

Coalition Letters

- Supporting increased funding for the NIH, FDA, and CDC – (3/16)
- Opposing an appropriations measure that would weaken the FDA's authority over several tobacco products including e-cigarettes and cigars (4/16)
- Supporting level funding for the Agency for Health Research Quality (AHRQ) – (5/16)
- Supporting level funding for the CDC Office of Smoking and Health (OSH) – (7/16)
- Opposing all appropriations policy riders that would weaken FDA's authority to regulate tobacco products – (9/16)
- American Academy of Pediatrics coalition letter concerning provisions in the Senate's 2017 National Defense Authorization Act (S. 2943) threatening pediatric subspecialist networks and GME
- American Academy of Pediatrics support letter for the Ensuring Children's Access to Specialty Care Act, allowing pediatric medical and surgical subspecialists and pediatric mental health specialists to participate in the National Health Service Corps loan repayment program

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Advocay Update: ACC in Action

ACC sent 31 Regulatory Letters in 2016

- Letter requesting that CMS implement a shortened reporting period in 2016 for the Meaningful Use EHR program.
- MIPS-APM proposed rule
- Physician Fee Schedule Proposed Rule (AUC, global services data collection, moderate sedation unbundling policy, specific codes, other items)
- Hospital Outpatient Proposed Rule (EHR reporting period, Section 603 site-neutral implementation, imaging APC assignments)
- Hospital Inpatient Proposed Rule (facility performance measures, new technology add-on payments, MS-DRG assignments)
- VA APRN proposed rule
- LAA NCD
- Leadless Pacemaker NCD
- Episode Grouper comments and nominations to clinical workgroup
- Venous Ischemic Limb Disease Medicare Evidence Development & Coverage Advisory Committee Meeting
- Part B Medication Demonstration Project Proposed Rule
- Update to UNOS/OPTN heart transplant criteria
- Medicare provider enrollment
- Ability of ACC to obtain Medicare claims data for research purposes
- Certification of EHRs for electronic measure reporting
- Draft PDUFA goals letter
- First proposed revisions to the Common Rule (the regulations governing research involving human subjects) in more than 20 years
- PDUFA & MDUFA stakeholder meetings as the FDA worked with industry to reach agreement. The results are borne out in the draft PDUFA agreement released last month (which we did comment on) and we think they are represented in the MDUFA agreement from what we know of it at this time (which we will comment on when released).
- Letter to FDA on sodium reduction targets
- Nominated Dr. Sherman to AHRQ National Advisory Council
- Medicare Shared Savings Program Benchmarking Rule Comments
- Comments to the LAN Cardiac Bundle White Paper
- Letter on the episode groups summary, patient encounter codes, supplemental episodes, and the clinical committee sign on
- Comments to the CMS measure development plan under MACRA
- JACC supplement on the population health summit, 2015
- First Lady Message for Opening Ceremony at ACC.16
- Letter to NHBLI on their website content
- Sign on letter to FDA on track and trace system for tobacco
- Sign on letter to FDA on new tobacco products
- Sign on letter to MLB on “knocking tobacco out of the park”
- Statement to USDA on Dietary Guidelines

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ACC Advocacy: May 2017 to Present

Advocacy Letters, Member Communications

31 Advocacy Letters Sent

ACC's Advocacy team sent 31 letters focusing on **health reform efforts in the House and Senate**, **tobacco regulations/research and smoking cessation** and **comments on CMS's proposed rule for the Medicare hospital inpatient prospective payment system**, among other topics.

13 Advocate newsletters sent to ACC members

4 press statements responding to health reform and the passage of medical liability legislation

26 advocacy articles published to *ACC.org*

7 advocacy-focused alerts delivered to ACC leadership

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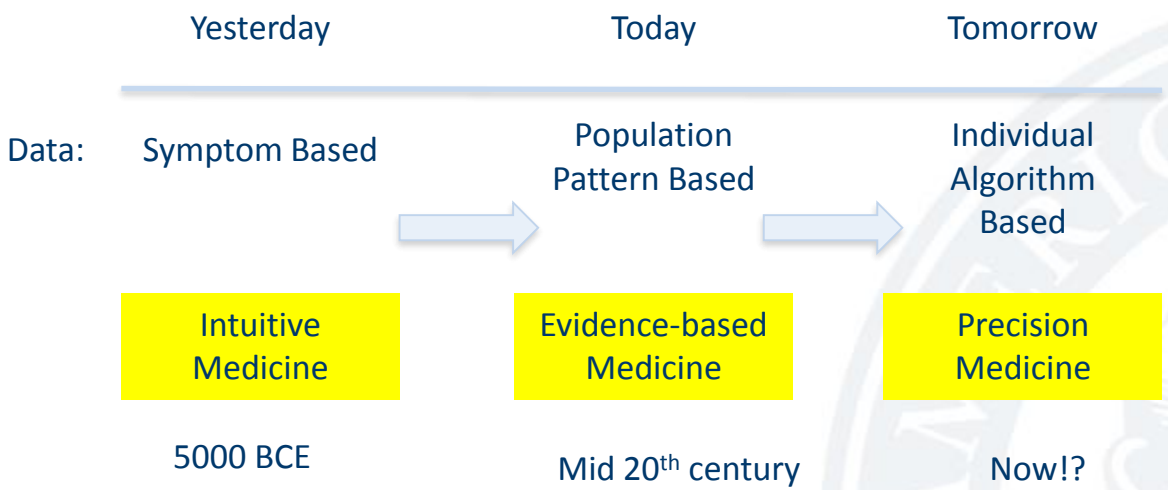
Transformation of Medicine: Data and Data Science



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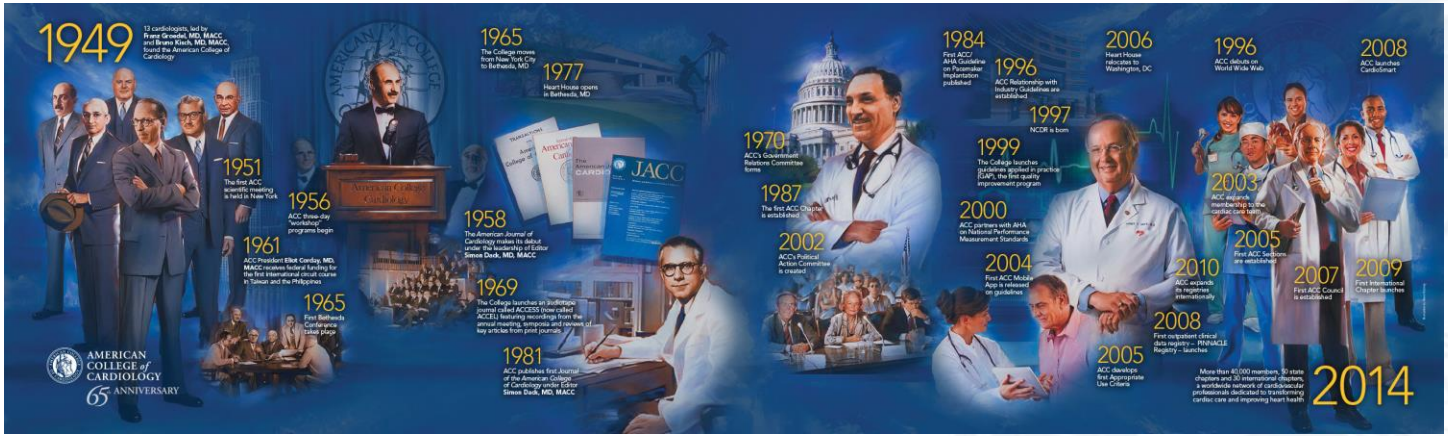

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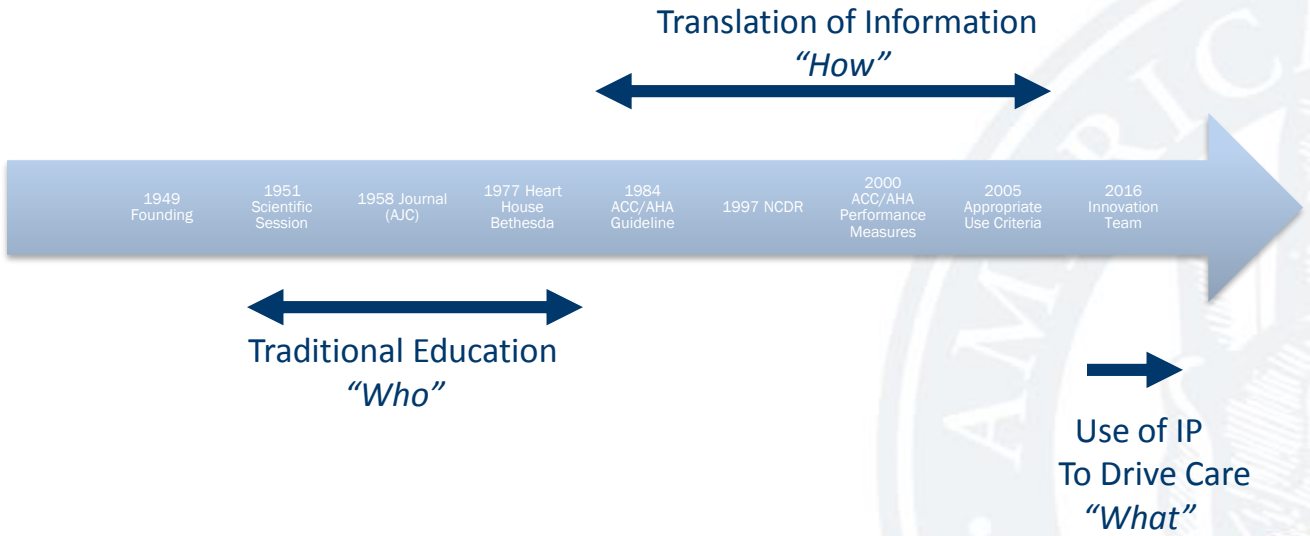
ACC Education Timeline



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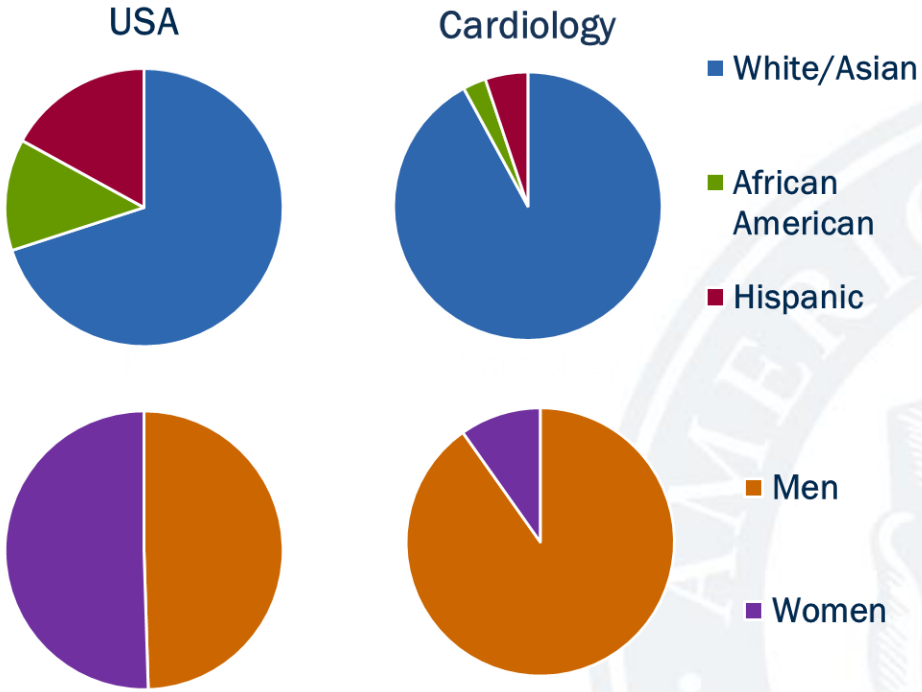
How Diverse is Cardiology?



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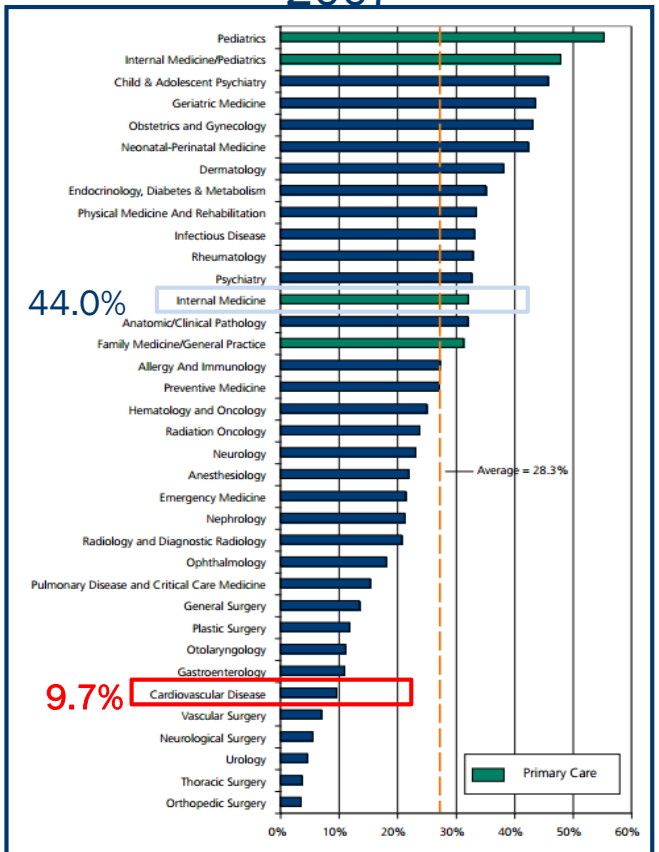
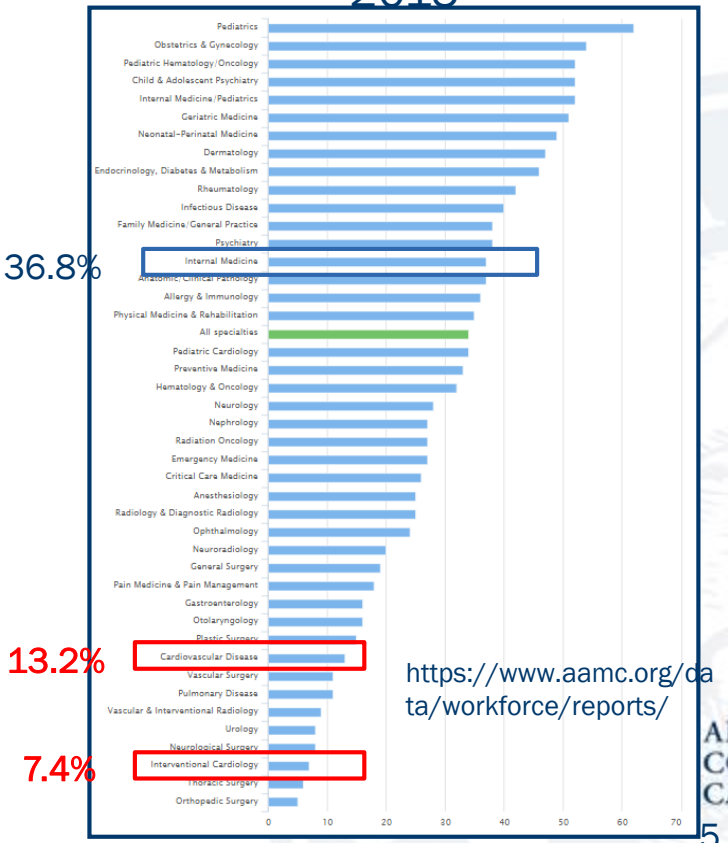
Women in Cardiology: Where We Stand Relative to 44 Other Specialties Over Time

2007



2015



https://www.aamc.org/data/workforce/reports/

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ACC Diversity and Inclusion Vision

- ACC will harness the power of the diversity of its members to advance patient care, spur innovation, and improve health equity among individual patients and populations.
- In doing so, the ACC will ensure opportunity for all cardiovascular providers by working towards a fully inclusive organization and profession.

ACC Core Values

- Diversity and inclusion are a component of ACC's new Core Values: **Patient-Centered, Teamwork and Collaboration, Professionalism and Excellence**

Moving toward solutions

To address these issues, the ACC Task Force on Diversity was formed in early 2017 and charged with providing recommendations to the BOT to enable the achievement of the following goals:

1. To ensure both cardiovascular medicine in general, as well as the ACC itself, attracts and provides rewarding careers for the full range of talented individuals in medicine.

2. To ensure both cardiovascular medicine in general, as well as ACC itself, benefits from diversity of backgrounds, experiences and perspectives in leadership, cardiovascular healthcare delivery, education and science.

3. To ensure the diverse needs of cardiovascular patients are met by cardiovascular clinicians sensitive to and respectful of their gender, cultural, racial and ethnic diversity.

The ACC's Three-Pronged Approach to MOC

- Serve as the trusted source of information about the changes for members
- Provide a wide range of educational materials for members who choose to participate in MOC
- Work with ABIM to improve the MOC process

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Dual ACCSAP Pathways
BOT approval 5.24.18

- **ACCSAP - Certificate**
  - Review questions only
  - 155 hours of CME
  - When completed, ACC will issue a "Certificate of Continuing Cardiovascular Professional Development" to the member
  - ACC member can submit results to:
    - State Licensing Boards
    - Payers
    - Hospital Credentials Committees
    - NBPAS, others

- **ACCSAP – MoC (CMP)**
  - Review and performance questions
  - 155 hours of CME and Part II MOC credit
  - When completed, ABIM will recognize that the Diplomate has maintained certification for 5 years
  - ACC member may submit results to:
    - State Licensing Boards
    - Payers
    - Hospital Credentials Committees
  - (Final approval by ABIM/ACC pending)

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ABIM & MOC: Looking Ahead

- The ACC and ABIM have been working together in good faith toward providing an alternate pathway for cardiologists who wish to maintain their ABIM certification. The shared goal is to continually improve all educational and assessment processes for physicians to stay current in knowledge and practice – ultimately in the service of better patient care.
- The ACC will have completed updates to three self-assessment programs (ACCSAP, EPSAP, and CathSAP) in early 2019. The goal: to integrate lifelong learning with assessment.
- ACC and ABIM are hopeful that this will form the basis for a general cardiology Collaborative Maintenance Pathway (CMP) in Q3 2019. This CMP will serve as an additional option to maintain ABIM cardiovascular certification.
- We are hopeful that other cardiology subspecialty CMPs in electrophysiology and intervention will be available in 2020.

MoC Responders

- **Type I**
  - See some value in maintaining ABIM certification
  - Not inclined toward NBPAS or starting a new CV board
  - Do not like Part III requirements
  - Quiet
  - Support negotiating with ABIM for an ACCSAP solution to Part III
- **Type II**
  - See no value in a corrupt and venal ABIM
  - ACC members should go with NBPAS or ACC should start a new CV board
  - Do not like any MOC requirements
  - Vocal
  - Support giving ABIM an ultimatum and then walking away

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How Many Type I's And Type II's Are Out There?

- Based on our estimates:
  - There are significant numbers of Type I's and Type II responders in the ACC
- Participation in ABIM MoC is a choice
- ACC should support options for all cardiologists – those who choose to participate in ABIM MoC and those who choose not to participate in ABIM MoC

MOC Policy: ACC is Also Watching:

- Multiple state legislative activities could impact the future of MOC
- Initial legislation has addresses and prohibited the use of MOC in licensing activities
- Potential limits on MOC use for hospital or payer credentialing
- Recent DOJ Investigation in Maryland

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Cardiovascular Summit

Contemporary Strategies for Quality Improvement, Operational Excellence, Finance and Leadership

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Feb 13-16, 2019

Orlando, FL

COURSE DIRECTOR
Howard T. Walpole Jr., MD, MBA, FACC

COURSE CO-DIRECTORS
Cathleen Biga, RN, MSN
Pamela S. Douglas, MD, MACC

Addressing ACC Member's Needs

Business of Medicine

Operational Excellence and
Quality Improvement

Leadership

Workforce Well-Being

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Department of Justice Letter to Maryland House of Delegates

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U.S. Department of Justice

Antitrust Division

Liberty Square Building

450 5th Street, N.W.
Washington, DC 20001

September 10, 2018

The Honorable Dan K. Morhaim, M.D.
The Maryland House of Delegates
6 Bladen Street, Room 362
Annapolis, MD 21401

Dear Delegate Morhaim:

In response to your request dated August 17, 2018,[1] the United States Department of Justice, Antitrust Division ("Division") welcomes the opportunity to share our views on Maryland House Bill 857 (the "Bill"), currently under review by a Maryland Health Care Commission ("MHCC") workgroup. You have indicated that the focus of this review is on the use by hospitals, insurers, and others of certification programs for physicians in medical specialties and, in particular, the Maintenance of Certification ("MOC") program as currently implemented by the American Board of Medical Specialties ("ABMS") and its member boards. We applaud the legislature for putting a spotlight on the potential impact of specialty board certification on competition in markets for physician services.

As described in your letter, you seek our views in two areas. First, you ask whether ABMS "may harm competition by imposing overly burdensome conditions on physicians who wish to maintain their certification."[2] According to your letter, ABMS, a private organization governed by market participants, has a monopoly in the certification of physicians in Maryland, and board certification functions as a de facto requirement for practice by physicians in

[1] Letter from Dan K. Morhaim, Delegate, Maryland House of Delegates, to Matthew Mandelberg, Antitrust Div., U.S. Dep't of Justice, & Daniel J. Gilman, Fed. Trade Comm'n (Aug. 17, 2018) [hereinafter *Letter*].

[2] *Id.* at 2.

DoJ Letter to Maryland House of Delegates

- Maryland Delegate Dan K. Morhaim, MD
  - NBPAS Board member
  - Certified in IM by ABIM, not participating in MoC
  - Asked DoJ Antitrust Division to opine on possible Maryland legislative actions
  - Outlined policy options if Maryland Legislature determines that ABMS's MoC harms healthcare competition in Maryland:
    - Do nothing, and let the market correct itself
    - Enact a law in which hospitals may not require physicians to maintain board certification
    - Promote competition between legitimate certifying bodies by recognizing a competitor to ABMS – the NBPAS – as a legitimate accrediting organization, potentially among others

DoJ Letter to Maryland House of Delegates

- Robert Potter, Chief of DoJ Antitrust Division Competition Policy and Advocacy Section
  - 14 page response to Maryland's options:
    - Do nothing, and let the market correct itself – **DoJ did not respond to this option**
    - Enact a law in which hospitals may not require physicians to maintain board certification – **DoJ encouraged Maryland legislature to continue allowing hospitals and insurers independently to decide whether to consider a physician's MoC status when making business decisions such as granting hospital privileges**
    - Promote competition between legitimate certifying bodies by recognizing a competitor to ABMS – the NBPAS – as a legitimate accrediting organization, potentially among others - **DoJ encouraged Maryland legislature to consider ways to facilitate competition by legitimate certifying bodies, consistent with patient health and safety**

DoJ Letter to Maryland House of Delegates

How did the ABMS respond to the DoJ letter?

American Board of Medical Specialties

Higher standards. Better care.®

American Board of Medical Specialties:
Statement on the U.S. Department of Justice Response Letter Regarding Proposed Maryland Legislation to Restrict Hospital and Health Plans Right to Set Quality Standards for Physicians

On September 10, 2018 the Antitrust Division of U.S. Department of Justice (DOJ) responded by letter to a request by Dr. Dan K. Morhaim, a Maryland state legislator and a board member of the National Board of Physicians and Surgeons, for input on a bill in the Maryland legislature that would, if enacted, restrict hospitals, health plans, and others from making their own independent judgments about the value of board certification in the credentialing of physicians. The request appears to have been motivated by Dr. Morhaim's objections to the Maintenance of Certification (MOC) program of physician certifying Boards that are members of the American Board of Medical Specialties (ABMS).

The MOC program is designed to help assure that physicians certified by ABMS Boards are committed to a program of lifelong learning, are keeping up with developments in their medical specialties, and are maintaining their medical knowledge, skills and expertise. The MOC program was put in place to advance the best interests of patients.

ABMS is pleased that the DOJ letter encourages the Maryland legislature "to continue allowing hospitals and insurers independently to decide whether to consider a physician's MOC status when making business decisions, such as granting hospital privileges" and ABMS strongly agrees with the conclusion of the DOJ that enactment of the Maryland bill could "harm, not improve, the competitive landscape of healthcare in Maryland." ABMS applauds the recognition by the DOJ of the value to consumers and health systems of "certifying that a provider has demonstrated a certain level of training, testing, or experience over and above other providers."

Like the DOJ, ABMS supports and encourages a competitive marketplace for specialty certification. At the same time, however, we are concerned about deception of patients if physicians are permitted to market themselves as "Board Certified" based on certification by a Board whose standards do not rigorously assess medical knowledge and maintenance of skills. After all, most consumers do not have the experience to differentiate between a claim of Board Certification based on the exacting standards of ABMS Boards and a claim of Board Certification not based on such standards.

For that reason, we believe that claims of Board certification should be based on transparent standards that will genuinely advance the interests of patients and avoid deception. We are confident that, when compared to any other specialty certification programs, ABMS Boards can clearly demonstrate the superiority of their certification programs in giving useful information to hospitals, payers, and patients. It is for this reason that hospitals, health plans, consumers, and even providers themselves, overwhelmingly select ABMS certification as the gold standard of specialty care.

While we continue to work with physicians and specialty and medical societies to ensure our programs do not become overly burdensome, we are proud that our certificate represents the highest standard of knowledge and assessment currently available. Accordingly, ABMS continues to welcome an accurate comparison of our programs to other certification programs currently in the marketplace, and we continue to support the right of patients and health systems to determine which program best meets their expectations for high quality specialty care.

DoJ Letter to Maryland House of Delegates

- ABMS: **The DoJ letter is reasonable**
  - Maryland legislature should continue to allow hospitals and insurers independently to decide whether to consider a physician's MoC status when making business decisions such as granting hospital privileges
  - Maryland legislature should consider ways to facilitate competition by legitimate certifying bodies, consistent with patient health and safety
    - The quality, dependability, and relevance of competing certifying bodies should be determined by the market
    - High quality certifying programs can expect to thrive

DoJ Letter to Maryland House of Delegates

- One other point
    - There is no apparent ongoing investigation of the ABMS or MoC by the DoJ Antitrust Division

Why are you getting into bed with the ABIM?

- The ACC (and sub-specialty societies) are not getting into bed with the ABIM.
- Board Certification and Maintenance of Certification are facts of life for ACC members.
- Approximately 55% of hospitals require Board Certification to grant privileges.
- The ACC is working with ABIM to create a less burdensome way for our members to maintain certification - rather than the 10-year high-stakes examination or the 2-year knowledge check-in.
- For ACC members who choose not to maintain their ABIM board certification, the new ACCSAP (and CathSAP, EPSAP, etc) will provide a mechanism to earn ~30 CME credits per year and will provide a “Certificate of Continuing Cardiovascular Performance Optimization” for member who earn these credits.

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