

## Fitness, Knowledge, Progress: Assessing Physician Qualification

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**OVERVIEW** — *The informed and empowered consumer is an ideal invoked by many would-be health care reformers. An actual consumer wishing to don the mantle of power may be hindered by the scarcity of information available, particularly with respect to choosing among physicians. How is one to know who is best qualified? This issue brief looks at the basics of physician qualification and the processes by which physicians are licensed, credentialed, and board-certified. It examines how the evolution of these processes (for example, the move from lifetime certification to ongoing maintenance of certification) affects clinicians and their patients. The rise of quality measurement and pay-for-performance programs is considered as well.*

# Fitness, Knowledge, Progress: Assessing Physician Qualification

It has long been a truism, borne out in many a survey, that Americans love their doctors. However much they may hate managed care, paperwork, or copays, they believe their own physicians know what they are doing and look out for patient interests. Americans also seem to believe that all health care is good, that no stone should be left unturned in diagnosing and treating their ills. Why take aspirin if you can have an MRI, one might ask, particularly given the blithe assumption that “insurance will pay for it.”

For many people—even beyond the nearly 46 million uninsured—that assumption is proving unfounded. Health plan sponsors have responded to rising medical costs by requiring consumers to shoulder more of the financial burden in the form of higher premiums, deductibles, and copays. Increasingly prevalent “consumer-directed” health plan offerings, which combine a tax-favored medical savings account with high-deductible insurance coverage, are explicitly founded on the theory that people spending their own money will scrutinize services and providers more closely and choose more thoughtfully among care options.

Assumptions about physicians are being challenged as well. More people are asking: How much of what doctors do is motivated by their practice’s bottom line or the source of their research grant? Is it a surprise that physicians with significant investment in—or paid substantial “consulting” fees by—device manufacturers are quite likely to use those devices? If the United States is home to cutting-edge health care, why is it that Americans receive care according to widely accepted clinical guidelines only about half of the time? The message to the American public is, “Don’t put too much faith in that white coat.” Physicians feel beleaguered. Policymakers wonder what information can be trusted. How does anyone know, or prove, that a clinician is qualified, competent, and practicing in a high-quality, cost-efficient manner?

During most of the modern era, the best a consumer could determine was that Dr. Smith had a license in one or more states, went to such-and-such a medical school, and (maybe) had been certified by a specialty society. This issue brief will discuss the traditional processes for validating physician competence—state licensure, health plan credentialing, and board certification—as well as how these are evolving. It will also describe additional strategies for distinguishing among physicians.

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## LICENSING

As the Federation of State Medical Boards (FSMB) notes, “The practice of medicine is not an inherent right of an individual, but a privilege granted by the people of a state acting through their elected representatives.”<sup>1</sup> The FSMB goes on to explain, “Each state charges its medical board with protecting the public from the unprofessional, improper, and incompetent practice of medicine.”<sup>2</sup> The legal framework for such protection generally takes the statutory form of a state medical practice act.

A state medical board comprises physicians and representatives of the public, generally appointed by the governor. For example, Ohio’s state medical board is prescribed to have nine physician and three consumer members, each serving five-year terms. Arkansas also created nine physician seats; of three members appointed at large, one must represent consumers and one the elderly. Board members in most states are paid a nominal stipend. The majority of boards employ full-time administrative staff. Funding, determined by each state’s legislature, often comes directly from licensing and registration fees. Board responsibilities include granting licenses to physicians deemed to have appropriate education and training and subsequently ensuring that they abide by recognized standards of professional conduct. In practice, such supervision mainly takes the form of examining complaints from consumers, monitoring malpractice data, and reviewing reports from health care institutions and government agencies.

The medical practice act in each state defines unprofessional conduct. Examples range from inadequate recordkeeping to conviction of a felony. A physician who is the subject of a consumer complaint of unprofessional conduct will have a formal hearing before the board, which then decides what action to take. A summary of disciplinary actions compiled by the FSMB lists a national total of 4,590 “prejudicial” actions taken in 2003 (the most recent year available). A prejudicial action involves a loss or restriction of license. Such actions are required to be reported to the National Practitioner Data Bank (NPDB), which in turn can be queried by authorized entities such as hospitals and health maintenance organizations (HMOs).

The NPDB is also supposed to be the repository of information on malpractice judgments and settlements as well as disciplinary actions taken by hospitals or professional societies that affect a physician’s privileges or membership. Noting that underreporting had been a concern since the data bank’s 1990 inception, the Government Accounting Office (GAO) found in 2000 that little had been done to address it.<sup>3</sup>

The NPDB is not accessible to individuals, but some state boards make physician-specific information available. For example, South Carolina in June 2005 passed a law requiring that disciplinary actions be made public. The California medical board posts disciplinary actions on its Web site.

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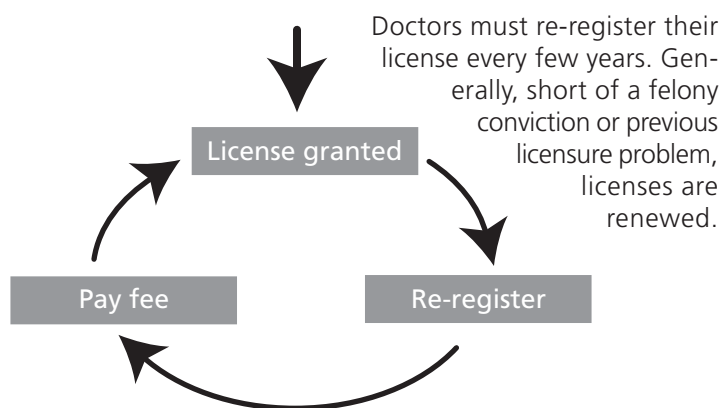
Candidates for initial licensure are required to demonstrate their capability by successfully completing the three-part United States Medical Licensing Examination (USMLE). The USMLE is designed to test a candidate’s basic understanding of the sciences underlying medical practice and his or her ability to apply them in patient care, in both supervised and unsupervised settings.<sup>4</sup> It is not specialty-specific. Results of the USMLE are furnished to state medical boards. (Physicians who graduated from medical schools outside the United States and Canada must take the additional step of being certified by the Educational Commission for Foreign Medical Graduates in order to enter U.S. postgraduate programs or to apply for state licensure.)

Licensed physicians must periodically re-register with their state to preserve active status. This involves demonstrating that they have maintained acceptable standards of ethics and practice, and, in some states, participated in continuing medical education. For example, Virginia requires the physician to participate in 30 hours’ worth of continuing education (at least half of which must be earned in an interactive, “face-to-face” setting as opposed to self-study) every two years. In the absence of a felony conviction or a license previously revoked, re-licensing at present is almost automatic with the payment of a fee. The FSMB has begun to consider whether more stringent re-licensure requirements should be imposed.

## Obtaining and Maintaining a License to Practice Medicine

Although testing to become a licensed physician is consistent nationwide, credential requirements vary by state.

<b>Test</b>	United States Medical Licensing Examination (USMLE)
<b>Credential</b>	Verification of training, schools attended



## CREDENTIALING

As part of their license application, physicians provide verification with respect to their medical schools, training programs, and hospitals or other settings in which they have worked. Subsequently, they may be required to furnish the same information to insurers whose networks they wish to join, or to provider networks directly. Even more documentation is required by hospitals in order to confer staff privileges. Although the Centers for Medicare & Medicaid Services (CMS), as a condition of participation in Medicare, requires hospital credentialing of physicians, there is no such requirement for physicians in office practice. Adherence to credentialing procedures by hospitals and insurers is also required by the Joint Commission for the Accreditation of Health Care Organizations and the National Committee for Quality Assurance (NCQA), though accreditation is itself a voluntary process.

Credentialing substantiates that a physician is trained and has been truthful about that training. It may also reassure (or caution) a health care organization about a physician's professional conduct history. As health plans are quick to point out, however, it does not guarantee a level of quality or service from physicians accepted by a network.

As an alternative to contacting past associates or institutions personally, physicians may turn to an entity specializing in verification. The Federation Credentials Verification Service (FCVS), established in 1996 by the FSMB, promises physicians—in return for a fee—a “permanent, lifetime portfolio of primary-source verified credentials” that can be forwarded at their request.<sup>5</sup> Many state medical boards require FCVS use. A similar service is offered by the Universal Credentialing DataSource (UCD), a product of the Council for Affordable Healthcare (itself an association of health insurers); the UCD has been endorsed by the American Medical Association (AMA).<sup>6</sup> The AMA also offers its own “ePhysician Profiles” primary source verification. Use of a verification service eliminates the continual filling out of credentialing applications. It can also provide a secure repository for those whose medical school records might be at risk in an unstable country or whose training programs have since been terminated.

## CERTIFICATION

Specialty boards were formed during the 20th century by physician leaders in response to “a perceived need to demonstrate quality and differentiate among specialties.”<sup>7</sup> What is now the American Board of Medical Specialties (ABMS) was founded in 1933. Each of its member boards, now numbering 24, has required certain levels of training and the passing of a rigorous written examination in order for its specialty physicians to be certified. In order to sit for board exams, a physician must have completed a residency certified by the Accreditation Council on Graduate Medical Education (ACGME).

For many years, initial certification was for a lifetime. The president of one ABMS board described this once-and-for-all certification as “an honorific credential.”<sup>8</sup> In recognition of the pace of change in medical knowledge, specialty boards [beginning with the American Board of Family Medicine (AAFM) in 1969] gradually began to issue time-limited certificates. Certified physicians, known as diplomates, who wished to maintain their status were then required to renew at six- to ten-year intervals. By 1990, all 24 boards had adopted the recertification model.

The next step in the evolution of certification has been a move from periodic recertification to a process labeled by ABMS as continuous “maintenance of certification” (MOC). By 2000, all the ABMS boards

had agreed to make this transition. According to the ABMS, maintenance of certification has four basic components, comprising evidence of:

- Professional standing
- Commitment to lifelong learning and involvement in a periodic self-assessment process
- Cognitive expertise based on performance on a proctored exam
- Evaluation of performance in practice

Underlying such evidence must be six general competencies defined by ACGME: medical knowledge, patient care, interpersonal and communication skills, professionalism, practice-based learning and improvement, and systems-based practice.<sup>9</sup>

Different specialty societies have put their own stamp on implementing the common MOC agenda. Some have developed tools to help physicians review their knowledge and undertake an analysis of their practice. For example, the American Board of Internal Medicine (ABIM) makes available a series of Practice Improvement Modules, designed to help physicians assess how their practice patterns compare to national averages, identify an area for improvement, and implement a quality improvement plan. The ABMS has been active in trying to standardize appropriate parts of the recertification process. The organization has indicated that it likely will endorse use of the CAHPS (Consumer Assessment of Healthcare Providers and Systems) physician-level survey as the standard patient survey instrument for most boards to use in practice evaluations.

ABIM officials have described MOC as only a first step, albeit a big one, in creating a habit of measurement and improvement that becomes “part of what it means to be a physician practicing in the 21<sup>st</sup> century.”<sup>10</sup> The ABIM is working to integrate its MOC program with other quality improvement initiatives, for example, linking its diabetes performance improvement module to NCQA’s Diabetes Physician Recognition Program. (NCQA’s physician recognition programs award recognition to physicians who demonstrate that they provide high-quality care to patients with specified diagnoses.<sup>11</sup>)

Physician reaction to MOC has been mixed. Most criticism seems to center on the self-evaluation components required by several boards. An AAFP member characterized the computer-based modules as “esoteric, not relevant to practice,”<sup>12</sup> while a gastroenterologist complained of “trivia questions with little clinical utility.”<sup>13</sup> The American Academy of Family Practice formally requested that the American Board of Family Practice make self-assessment optional, at least initially. (The board declined to do so, but did make multiple adjustments to the MOC process on the basis of physician feedback.)

**Maintenance of certification is “part of what it means to be a physician practicing in the 21<sup>st</sup> century.”**

Physicians whose initial, unlimited certifications were issued before 1990 have not been required to undergo recertification, though some choose to do so voluntarily.<sup>14</sup> Although eliminating this grandfather clause might provoke membership rebellion in the specialty societies, research shows there may be reason to consider it. A systematic review of studies looking at the relationship between clinical experience (or time since medical school) and health care quality found that physicians who have been in practice longer may be at risk for providing lower-quality care. The authors offer as perhaps the most plausible explanation that physicians' "toolkits" are created during training and may not be updated regularly.<sup>15</sup>

Troyen A. Brennan, MD, JD, describing in the *New England Journal of Medicine* his own decision to pursue MOC voluntarily, explains that many physicians regard the exam as a hurdle. He writes, "Physicians complain that it is high-stakes (those with time-limited certificates don't want to lose them), irrelevant (it doesn't test the knowledge that internists need), not useful (one isn't a better doctor for having taken it), and time-consuming."<sup>16</sup>

A response to such objections is offered by Richard Baron, MD, who writes in the same publication, "Seen as something imposed on the profession from outside, [maintenance of certification] can feel like one more irritation. But what if we embraced a commitment to practice-based improvement as our own professional goal?"<sup>17</sup>

With the controversy over MOC, the question might well be asked, "Why bother to be certified at all?" Some physicians choose not to. However, "board-certified" may be an attribute required by health plans for participation in their physician networks or by hospitals in order to secure admitting privileges.<sup>18</sup> In other words, there is a correlation between certification and income.

Patient insistence on certification still seems underdeveloped. Although a Gallup poll conducted for ABIM in 2004<sup>19</sup> found that 54 percent of

### Through the Years: The Evolution of Certification

Since the establishment of the American Board of Medical Specialties, three approaches to becoming board-certified have been implemented for licensed professionals.

Licensed Doctor	Certification 1933 to 1969	Periodic Recertification 1969 to 1990	Maintenance of Certification 2000 to present
<b>Certification Period</b>	Lifetime diplomate	Recertify every 6 to 10 years	Recertify every 7 to 10 years
<b>Requirement</b>	Accredited residency and board examination	Board examination	Unrestricted license, board examination, self-evaluation of medical knowledge and practice performance

respondents would be “very likely” to seek a new doctor if they found their current physician’s certification had expired, one may legitimately wonder whether these conclusions were reached after copious explanation of what certification is, exactly. Perhaps the message is that consumer education is an important element in any strategy intended to hold physicians accountable.

## A FEDERAL ROLE?

All legally practicing physicians must have a state license. No one is required to join a specialty society or, as noted, to be certified. Is the combined oversight by the state and the profession sufficient to protect patients, ensure quality, and deliver value for money? Some would argue that the federal government should be involved as well, though other analysts raise questions about the federal government’s right to regulate commerce that usually occurs within state boundaries.

One context in which a federal qualification process has been discussed is in responding to disaster, be it a hurricane or the onset of an epidemic. To what extent do differing state licensure requirements get in the way of physicians responding to a public emergency, or those who must relocate as a result? In the aftermath of Katrina, and in recognition of a public health emergency, Louisiana Gov. Kathleen Blanco issued an executive order suspending state licensure requirements for out-of-state medical professionals coming to Louisiana who possessed current medical licenses in good standing in other states.<sup>20</sup> Some analysts have called for a cross-state licensing process to be instituted in order to ensure that medical resources can be assembled quickly from a variety of locations at times of great need.

Another aspect of the cross-state licensing question is where records would be kept and who would have access to them. Certainly there have been cases where a physician—or, for that matter, someone posing as a physician—has been disciplined in one state only to surface, apparently clean, in another. Should all states have access to each other’s physician information? Should a federal agency be in control? Would a practical solution be to open the NPDB to the public after all?

A separate context in which possible federal action has been raised encompasses both the quality and the cost of certain services provided to Medicare beneficiaries. As physicians add more in-office services to their practices, the volume of such services increases accordingly. Writing in *Modern Healthcare*, Medical Group Management Association President William Jessee cites office-based services as a means to increase physician compensation and as possibly “the only route a medical group can take to keep its doors open.”<sup>21</sup> (Other observers question how many practices

**Is combined oversight by the state and the profession sufficient to protect patients, ensure quality, and deliver value for money?**



have actually gone out of business for reasons beyond mismanagement.) Spending for imaging services, for example, has grown more than 60 percent between 1999 and 2003,<sup>22</sup> and their migration from hospital to outpatient settings led the Medicare Payment Advisory Commission (MedPAC) to study their proliferation. In its March 2005 report, the Commission recommended that Congress direct the Secretary of Health and Human Services to set standards for physicians who bill Medicare for performing and/or interpreting diagnostic imaging services.

MedPAC acknowledged that requiring physicians to meet quality standards as a condition of payment for imaging services would represent a major change in Medicare payment policy. Whereas hospitals have been subject to standards that serve as “conditions of participation” from Medicare’s inception, the program has paid for all “medically necessary” services provided by physicians who are licensed in the state where they practice and who agree to accept Medicare reimbursement rates.

Not surprisingly, the proposal has been controversial. Radiologists were already engaged in a turf war with specialists who provide or interpret imaging studies in their own offices rather than by referral to a hospital or radiology center. For the latter group, increased revenue is an effective motivator. Although federal law restricts physicians’ ability to refer patients for radiology services in which they (the physicians) have an ownership interest, an exception is made for “in-office ancillary services.” The Coalition for Patient-Centered Imaging, formed by nonradiology specialist groups in response to the MedPAC report, warned Congress not to let CMS be the judge of who is qualified to deliver imaging services. The physician’s personal knowledge of the patient’s condition and the patient’s own convenience are cited as reasons to preserve choice.<sup>23</sup>

Imaging may be only the opening salvo. Some analysts suggest that imposing Medicare conditions of participation on physicians would be a powerful lever for ensuring and monitoring quality. The requirements might include adoption of electronic medical records, collection and reporting of quality data, or other changes deemed conducive to a higher-quality, more efficient health care system. They note that other Medicare providers with similar levels of infrastructure, such as home health agencies and dialysis facilities, are already subject to significant quality reporting requirements.

Short of formal conditions of participation is the kind of incentive that CMS has already applied to hospitals with respect to quality reporting: money. When hospitals were first given the opportunity to report data on defined quality measures and to receive feedback on their performance, participation was sluggish. Then dollars came into play, and hospitals were told, in effect, “You don’t have to do this. But you’ll be paid less if you don’t.” The Physician Voluntary Reporting Program, due to take effect in 2006, does not (yet) incorporate a similar financial

**Requiring physicians to meet quality standards as a condition of payment would represent a major change in Medicare payment policy.**

incentive. However, the Medicare Value Purchasing Act (S. 1356), introduced by Sen. Chuck Grassley (R-IA) in 2005, would reduce physicians' reimbursement by two percent if they fail to report quality data by 2007.

## PHYSICIAN ACCOUNTABILITY: LOOKING FORWARD

As the evolution of certification indicates, 21st-century payers are not content with the old "prove yourself once" model of physician qualification. In part, this discontent reflects the sheer volume of new clinical information now being generated. It is also a response to well-publicized documentation of poor-quality care, such as the Institute of Medicine's 1999 *To Err is Human* or Elizabeth McGlynn and colleagues' 2003 "The Quality of Care Delivered to Adults in the United States," which found that patients receive recommended care only 55 percent of the time.<sup>24</sup> Physicians are being asked to demonstrate and indeed upgrade their skills.

Pay-for-performance (P4P) programs, which frequently tie financial reward to attainment of specified standards of care, are proliferating under the sponsorship of health plans, employers, and even some physician groups. Once again, reactions have been mixed. While some physician leaders have applauded the P4P concept as long overdue, the prospect of being measured and compared to others is not native to physician culture. The American Medical Association's *Guidelines for Pay-for-Performance Programs* is very prescriptive as to the kinds of measurement, risk adjustment, reimbursement, and other requirements they consider acceptable.<sup>25</sup>

With the addition of P4P arrangements, a physician may now be, or feel, judged by the state (or states, in the case of some telemedicine practitioners), his or her professional society, multiple health plans, patients armed with Internet printouts, and, waiting in the wings, the federal government. While a degree of exasperation is understandable, there is momentum in both the public and private sectors to expand P4P.

It might seem that "getting used to it" is in order. P4P continues to gain momentum. The Leapfrog Group, a consortium of health care purchasers dedicated to improving the safety, quality, and affordability of health care in the United States, is documenting the spread of P4P programs. Leapfrog's Incentive and Reward Compendium detailed 93 operational P4P programs at the end of 2005. In addition, MedPAC Executive Director Mark Miller, responding to a question following testimony before the Subcommittee on Health of the House Committee on Ways and Means in March 2005, said that he "would not close the door" on the possibility that he could be back to talk to subcommittee members about regulating services in addition to imaging.<sup>26</sup> Many outside the medical profession continue to express skepticism about the level of "self-policing" it has demonstrated to date.

On the other hand, multiple discrete and uncoordinated efforts to measure performance, improve quality, and generally keep physicians on their toes may be seen as adding to the overall fragmentation of care delivery. It certainly adds to the modern physician's storied disenchantment with the practice of medicine.

There appears to be consensus that "trust me" is not the mantra to quell all concern with physician behavior. The profession might do well to embrace an effort to restore its luster through a demonstrated commitment to quality improvement, as suggested by Dr. Baron and others. Regardless of whether medical professionals choose to embrace quality improvement on their own, the crowd of other stakeholders willing to impose such a commitment continues to grow.

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