2019 HOUSE INDUSTRY, BUSINESS AND LABOR

HB 1433

2019 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1433
1/29/2019
31746

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Ellen LeTang

Explanation or reason for introduction of bill/resolution:

Maintenance of certification for physicians.

Minutes: Attachment 1, 2, 3, 4, 5, 6

Chairman Keiser: Opens the hearing on HB 1433.

Rep Kasper~Distrct 46: Introduces HB 1433 & it deals with maintenance of certification (MOC). There is a problem with certification for MOC.

Courtney Koebele~Executive Director-ND Medical Association: Attachment 1, 2 & 3.

9:50

Rep Adams: The CME, isn't that standard?

Courtney Koebele: That CME (current medical education) is maybe not the standard but there are people who are here that can answer that better.

Rep Adams: Once they are done with their specialty, isn't there a standard to maintain for continuing ed & is it the board who sets the standard?

Courtney Koebele: Physicians have to take the MOC in order to maintain their license that the medical board approves. There are different boards that maintain that certification & the bill allows more choice.

Rick Becker~Physcian: Attachment 4. I wasn't aware of this bill. I sent this letter concerning MOC. Talks about his experience & that MOC is a farce & an embarrassment.

18:45

Rep C Johnson: Is the MOC used by the insurance to deny claims?

Rick Becker: I'm not aware of anyone that hasn't been covered but it does eventually effect the person.

Rep Adams: Who maintains the MOC?

Rick Becker: It's the American Society of Plastic Surgeons for plastic surgery. It's a national thing.

Rep Kasper: MOC ceases to become required, how will you continue to be qualified in what you do?

Rick Becker: The CME's maintain the certification with class 1 & class 2.

Rep Kasper: Do you think that if you stopped the MOC's, will there be retribution?

Rick Becker: I don't think there would be retribution but they could get entangled with other things.

Vice Chairman Lefor: Where did the MOC come into being & why did it start?

Rick Becker: If I want to keep my MOC & jump through the hoops. It came from a push from other medical specialties. There was concern that the government would start governing & boards wanted to implement their own.

Vice Chairman Lefor: If you don't do the MOC, how will that affect you.

Rick Becker: I can't have hospitals privileges & ER's. Without certification, I can't get insurance.

Fadel Nammour~Gastroenterologist with an established practice, Fargo: Attachment 5.

39:35

Rep Adams: If MOC doesn't certify you & you need to be renewed, is that the national board that will renew your license?

Fadel Nammour: What we are trying to achieve here is to choose.

Chairman Keiser: The amendment takes out all my concerns. I curious about the rational of the amendment.

Fadel Nammour: We believe in choice. We are protecting the rights hospital, facilities but the rights of physicians.

Chairman Keiser: It does create transparency. Section 4, why did you remove that.

Fadel Nammour: We don't think it would be an issue taking it out.

Rep Kasper: What percent of physicians would support this bill.

Fadel Nammour: I believe, all of them, well, the majority of them.

44:20

Tom Strinden~Estalished Ophthalmology Practice, speaking on behalf of the NDSEPS & the NDMA: Attachment 6.

55:10

Misty Anderson~Internal Medical Physician in Valley City: Expresses the concern that everyone wants something done about MOC. I like the choice.

Chairman Keiser: Anyone else here to testify in HB 1433. Closes the hearing. What are the wishes of the committee?

Rep Kasper: Moves the adoption of the amendment 19.0967.01001.

Vice Chairman Lefor: Second.

Voice vote ~ motion carried.

Chairman Keiser: What are the wishes?

Rep Kasper: Moves a Do Pass as Amended on HB 1433

Rep D Ruby: Second.

Chairman Keiser: Further discussion?

Roll call was taken on HB 1433 for a Do Pass as Amended with 12 yes, 0 no, 2 absent & Rep M Nelson is the carrier.

DP 1/29/19

19.0967.01001
Title.02000

Adopted by the Industry, Business and Labor Committee

January 29, 2019

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1433

Page 1, line 1, remove ", a new section to chapter"

Page 1, line 2, replace "23-34," with " and"

Page 1, line 2, remove ", and a new section to chapter 31-04"

Page 1, line 18, remove "alternative, regulated"

Page 1, line 22, remove ". A physician is considered a board certified"

Page 1, remove line 23

Page 2, remove line 1

Page 2, line 2, replace "participation or status" with "and having requirements in addition to those the North Dakota board of medicine requires to practice medicine"

Page 2, line 20, after "differentiation" insert "and the facility's governing body approves the vote"

Page 2, remove lines 21 through 23

Page 2, line 24, replace "(2)" with "(1)"

Page 2, line 25, remove "limiting the differentiation to"

Page 2, line 26, remove "certain medical specialties,"

Page 2, after line 28, insert:

"(2) This section may not be construed to require a new vote by the facility's medical staff.

(3) Notwithstanding paragraph 2, this section may not be construed to abrogate or supersede the ability of an organized medical staff and governing board of an individual facility to determine the facility's credentialing and privileging criteria with respect to board certification and maintenance of certification requirements."

Page 3, remove lines 1 through 5

Page 3, remove lines 19 through 23

Renumber accordingly

Date: Jan 29, 2019

Roll Call Vote #: 1

2019 HOUSE STANDING COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. 1433

House Industry, Business and Labor **Committee**

☐ **Subcommittee**

Amendment LC# or Description: 19.0967.01001 title .02000

Recommendation

☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions ☐ Reconsider ☐ _____

Motion Made by Rep Kasper **Seconded By** Rep Lefor

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser			Rep O'Brien		
Vice Chairman Lefor			Rep Richter		
Rep Bosch			Rep Ruby		
Rep C Johnson			Rep Schauer		
Rep Kasper			Rep Adams		
Rep Laning			Rep P Anderson		
Rep Louser			Rep M Nelson		

Total (Yes) _____ No _____

Absent _____

Floor Assignment voice vote - motion carried

Date: Jan 29, 2019

Roll Call Vote #: 2

2019 HOUSE STANDING COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. 1433

House Industry, Business and Labor **Committee**

☐ **Subcommittee**

Amendment LC# or Description:

Recommendation

☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☒ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions ☐ Reconsider ☐

Motion Made by Rep Kasper **Seconded By** Rep Ruby

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser	X		Rep O'Brien	X	
Vice Chairman Lefor	X		Rep Richter	X	
Rep Bosch	X		Rep Ruby	X	
Rep C Johnson	X		Rep Schauer	AB	
Rep Kasper	X		Rep Adams	X	
Rep Laning	X		Rep P Anderson	X	
Rep Louser	AB		Rep M Nelson	X	

Total (Yes) 12 No 0

Absent 2

Floor Assignment Rep Nelson

REPORT OF STANDING COMMITTEE

HB 1433: Industry, Business and Labor Committee (Rep. Keiser, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (12 YEAS, 0 NAYS, 2 ABSENT AND NOT VOTING). HB 1433 was placed on the Sixth order on the calendar.

Page 1, line 1, remove ", a new section to chapter"

Page 1, line 2, replace "23-34," with " and"

Page 1, line 2, remove ", and a new section to chapter 31-04"

Page 1, line 18, remove "alternative, regulated"

Page 1, line 22, remove ". A physician is considered a board certified"

Page 1, remove line 23

Page 2, remove line 1

Page 2, line 2, replace "participation or status" with "and having requirements in addition to those the North Dakota board of medicine requires to practice medicine"

Page 2, line 20, after "differentiation" insert "and the facility's governing body approves the vote"

Page 2, remove lines 21 through 23

Page 2, line 24, replace "(2)" with "(1)"

Page 2, line 25, remove "limiting the differentiation to"

Page 2, line 26, remove "certain medical specialties,"

Page 2, after line 28, insert:

"(2) This section may not be construed to require a new vote by the facility's medical staff.

(3) Notwithstanding paragraph 2, this section may not be construed to abrogate or supersede the ability of an organized medical staff and governing board of an individual facility to determine the facility's credentialing and privileging criteria with respect to board certification and maintenance of certification requirements."

Page 3, remove lines 1 through 5

Page 3, remove lines 19 through 23

Renumber accordingly

2019 SENATE INDUSTRY, BUSINESS AND LABOR

HB 1433

2019 SENATE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Roosevelt Park Room, State Capitol

HB 1433
3/4/2019
JOB # 33122

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Florence Mayer

Explanation or reason for introduction of bill/resolution:

Relating to maintenance of certification for physicians; and to declare an emergency.

Minutes: Attachment # 1 - 4

Chairman Klein: Called the meeting to order on HB 1433, all members were present.

Representative Rick Becker, District 7: Introduced the bill and provided Attachment #1. In a nutshell, this is about maintenance of certification for physicians. There is a whole process, stringent requirements and testing. We are required to maintain CMEs, Continuing Medical Education. The maintenance of certification can become an arduous process, time consuming and costly. These hours of paperwork, not edifying knowledge, occurs every 3 years. On the 10th year, there is a big test. The letter I submitted to you was a let I wrote to the editor of the journal for the American Society of Plastic Surgeons telling them the process was a sham. Continued with a personal story of how when taking his last national test he had failed until he bought their DVD set, in which he then scored a 100%. The test costs hundreds of dollars, the stay in a hotel, and travel to Minneapolis, all very expensive. After the first time and failing taking 4 hours, the second time with the DVDs it took him an hour. Every single answer was in the DVDs, so that he did not even have to read the question, to know the answer. This does not protect the public; it secures the relative validity of the boards. I am advocating for this bill, because it states this maintenance of certification process probably does not warrant the credence we give it.

(6:00) Senator Piepkorn: What would be the purpose of the boards wanting to fill the coffers? What do they do with that money?

Representative Becker: I think there is a natural tendency to create this perceived need for greater intervention. It may have come out of good intentions at the beginning with protecting the public from physicians that had not done any continuing education in years. Now, there is a lot of money going into this and a lot of lost productivity. It is not doing anything to help the public.

Senator Piepkorn: Is there any consistency between special fees with different areas of practice?

Representative Becker: I cannot answer that. They work along the same protocols; they have different requirements.

Chairman Klein: We might get that answer I see shaking heads behind you.

Senator Vedaa: Is this legislation unique to North Dakota, or are other states doing this?

Representative Becker: That is a question you would think I would have the answer to, but I do not.

Chairman Klein: I see nodding heads again on that.

Courtney Koebele, Executive Director of the North Dakota Medical Association: Testified in support of HB 1433 and provided Attachment #2. Introduced Fadel Nammour and Tom Strinden, both from Fargo.

Fadel Nammour, President of North Dakota Medical Association: Testified in favor of HB 1433 and provided Attachment #3.

(22:07) Senator Piepkorn: What does CME stand for?

Fadel Nammour: Continuous Medical Education.
(Continued testimony on page 3.)
Just to answer questions from before, there is no consistency between different medical specialty boards. Every board has its way to determine what they will use. The money goes to financial salaries, buying condominiums, spending money unwisely.

(26:09) Chairman Klein: Can North Dakota carve ourselves out? This isn't a national thing?

Fadel Nammour: 11 states have already done that. This is not a federal requirement; it is just a decision by facilities.

Chairman Klein: Your facility can determine whether you do this? There is that flexibility? (That was confirmed.)

Senator Kreun: If we do this, who will be responsibility to make sure the new group will do what it is supposed to?

Fadel Nammour: I am not sure what group you are talking about. The facility itself would be the one to oversee physician credentials.

Senator Kreun: If we put this into law, is the Attorney general going to make sure you are doing what the CME does? This is going to be a law it is not voluntary anymore. Who will oversee this?

Fadel Nammour: Many things can oversee this law. The hospitals, board of Medical Examiners. If there are any lawsuits then the Attorney General can get involved. You do not need a group, it is already there. There are already boards to oversee position credentials.

Chairman Klein: The way you see this, the hospital board would say you do not have to do this anymore, we have exempted ND. If this organization comes after you, they would have to sue the hospital, probably the credential board and have to determine actions from there.

Fadel Nammour: The ABMS cannot sue the hospital for the board of certification. The hospital made the decision to accept ABMS or to accept some other board for credentialing.

Senator Kreun: If you were acting like the NCAA before, are we taking away in chapter 2316, are we taking out anything or just adding?

Fadel Nammour: We are not taking anything away, just changing the process. There will still be board certification. It will be a choice between this board and that board.

Senator Roers: Have the hospitals endorsed this plan?

Fadel Nammour: Yes, that is why the bill was amended after talking with them. We have their approval on those changes.

Chairman Klein: And since you are the president of the medical group, you guys like it too?

Fadel Nammour: Yes.

(31:42) Dr. Tom Strinden, speaking on behalf of NDSEPS and the NDMA: Testified in support of HB 1433 and provided Attachment #4.

(42:24) Senator Burckhard: You say you are proud that North Dakota is a “right to work state”, that is because?

Dr. Strinden: I have become a member of the union without knowing it. That union is the ABMS and American Board of Ophthalmology. It was eluded to that 5.4B over 10 years, they have lobbyists, but they never showed up to stand against us because they do not have a leg to stand on. We need to protect the ability to practice. You do not need to be board certified to practice in North Dakota. 95% of physicians in North Dakota agree with this. I want an alternative to provide for our physicians.

Chairman Klein: I do not know when North Dakota became a right to work state, but Wisconsin was in the last few years.

Senator Kreun: We do not have anything in code right now to do anything you are talking about. Right now, a non-profit organization governs itself. Putting this into law, you will not be able to govern yourselves. There is nothing in the Century Code right now about this. Unless I am wrong? If we put this into law, you will be governed by us.

Dr. Strinden: Courtney please come up. The recommendation would be that we do not have a requirement for MOCK in order to practice. That is what the ABMS vision study recommended. We are also allowing an alternative board to come in. We do not care who is overseeing us as long as they have our best interest in mind. We found with the ABMS and that money train, they treat us as if we are just funding a bigger bureaucracy. We are trying to bring that down a notch.

Senator Kreun: I am not opposed to this, just wondering where it fits in.

Courtney Koebele: This is all new law. It will be in the insurance code and the hospital code that governs hospitals.

Chairman Klein: It is like any other rule or law we put in affect. It is governed by the section of the code that it is in. If there are any issues with the MOCK group turning on the state of North Dakota, we are looking at a 'what if' situation. The Attorney General defends all the laws North Dakota passes, but I do not think it would get to that point.

Courtney Koebele: I agree, it just makes it clear that it is an optional program. ABMS would have no stand to challenge this. This complies with all the hospital requirements.

Chairman Klein: I would suggest after the hearing, Senator Kreun, you would look for that comfort level off line. We do not want to be willy-nilly letting these docs do patient care.

Courtney Koebele: I worked with Jennifer Clark to draft this bill.

Chairman Klein: Called for any further testimony. Closed the hearing on HB 1433.
Senator Kreun, you have some work to do. Get to your comfort level and we will work on this later. Recessed committee.

2019 SENATE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Roosevelt Park Room, State Capitol

HB 1433 Vote
3/4/2019
JOB # 33132

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Florence Mayer

Explanation or reason for introduction of bill/resolution:

Relating to maintenance of certification for physicians; and to declare an emergency.

Minutes: None.

Chairman Klein: Called committee to order to do work on HB 1433.

Senator Kreun: Having understood the goals of the individuals, I move a Do Pass on HB 1433.

Senator Roers: Seconded.

Senator Klein: This multi-billion dollar organization doesn't like states dropping out of their groups.

Senator Kreun: They simply want a governing position so that it is fair and equitable to their group.

A Roll Call Vote Was Taken: 6 yeas, 0 nays, 0 absent.

Motioned carried.

Senator Kreun will carry the bill.

Chairman Klein: Adjourned the committee.

Date: 3-4-19
Roll Call Vote #: 1

2019 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB1433

Senate Industry, Business and Labor Committee

☐ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Kreun Seconded By Roers

Senators	Yes	No	Senators	Yes	No
Chairman Klein	✓		Senator Piepkorn	✓	
Vice Chairman Vedaa	✓				
Senator Burckhard	✓				
Senator Kreun	✓				
Senator Roers	✓				

Total (Yes) 6 No 0

Absent 0

Floor Assignment Kreun

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1433, as engrossed: Industry, Business and Labor Committee (Sen. Klein, Chairman) recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1433 was placed on the Fourteenth order on the calendar.

2019 TESTIMONY

HB 1433

Attachment 1

NDMA
Est.1887 NORTH DAKOTA MEDICAL ASSOCIATION

House Industry Business and Labor Committee
HB 1433
January 29, 2019

Good morning Chairman Keiser and Committee Members. I am Courtney Koebele and I serve as executive director of the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents, and medical students.

HB 1433 is one of many bills that have been filed and passed throughout the country regarding a growing controversy – Maintenance of Certification (MOC). Almost a dozen states have passed laws, and many more have pending bills this legislative session. Most recently, Michigan passed a bill last month that prohibits the use of MOC for certain specialties.

What is MOC? After physicians complete their residency, they may choose to take a certification exam by one of the several boards governed by the American Board of Medical Specialties (ABMS). This initial board certification must be maintained through a series of the tests and other activities called MOC. No medical board in the country requires specialty certification for licensure or MOC for licensure.

This bill arose out of concerns expressed by many physicians regarding the costs and efficacy of testing required for MOC by national

medical specialty certification boards, as well as concerns about the use or potential use of MOC by insurance plans and health care facilities as a "de facto mandate on physicians."

NDMA passed a resolution last year regarding MOC as follows:

1. That NDMA acknowledge that the requirements within the Maintenance of Certification process are costly and time intensive, and they result in significant disruptions to the availability of physicians for patient care.

2. That NDMA acknowledge that after initial specialty board certification, the NDMA affirms the professionalism of the physician to pursue the best means and methods for maintenance and development of their knowledge and skills.

3. That NDMA reaffirms and encourages the value of continuing medical education, while opposing mandatory Maintenance of Certification as a requirement for licensure, hospital privileges, and reimbursement from third party payers.

This bill does not limit the use of initial board certification for credentialing, nor is it in any way a statement in support of less learning by physicians or reduced quality of care. This bill allows more choice for physicians and in some states it's called a "right to work" act.

HB 1433 puts definitions into the century code about maintenance of certification and allows for a Hospital's medical staff to choose whether it will require maintenance of certification. HB 1433 would prohibit the use of maintenance of certification (MOC) as the sole basis for health insurance plan reimbursement and/or credentialing.

I plan on stepping through the bill and have a couple of members that will explain the history of the issue, and why it's a good idea for North

Dakota to pass this bill. We have been working with interested stakeholders and have some amendments, which are attached.

The first section of the bill defines continuing medical education, maintenance of certification, physician and specialty medical board certification. The amendments simplify both section b, maintenance of certification, and d., specialty medical board certification.

The next part of the bill prohibits hospitals from using MOC, except through section 5.

On page 2, line 12, section 5 details the exception for the facility to allow differentiation. This section allows the facility to differentiate if their designation is contingent on their physicians maintaining certification, or if its medical staff votes to differentiate, and it is approved by its governing board. Nothing in the section is construed to require a new vote by the medical staff. Nothing in the section is meant to abrogate or supersede an individual facility's organized medical staff and governing board to self-determine credentialing and privileging.

The amendments then take out sections 2 and 4 of the bill.

Finally, section 3 of the bill prohibits a health care insurer to deny reimbursement to or prevent a physician from being a preferred provider based solely on a physician's decision to not participate in MOC, and it may not discriminate with respect to reimbursement levels based solely on a physician's decision to not participate in MOC.

Thank you for your time today. NDMA would urge a DO PASS, AS AMENDED, on HB 1433. I would like to introduce Fadel Nammour, MD and Thomas Strinden, MD, who will be following me, and explain in more detail the background of MOC, and why we are supporting this bill. I would be happy to answer any questions.

Attachment 2
Jan 29, 2019

19.0967.01000

Sixty-sixth
Legislative Assembly
of North Dakota

HOUSE BILL NO. 1433

Introduced by

Representatives Kasper, Becker, B. Koppelman, Rohr, Strinden, Vigesaa

Senators Clemens, Davison, Dever, J. Lee, Oehlke

A BILL for an Act to create and enact a new section to chapter 23-16, ~~a new section to chapter 23-34~~, a new section to chapter 26.1-47, ~~and a new section to chapter 31-04~~ of the North Dakota Century Code, relating to maintenance of certification for physicians; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 23-16 of the North Dakota Century Code is created and enacted as follows:

Maintenance of certification.

1. As used in this section:
   a. "Continuing medical education" means continued postgraduate medical education required by the North Dakota board of medicine intended to educate medical professionals about new developments in the medical field.
   b. "Maintenance of certification" means a process requiring periodic recertification examinations or other activities to maintain specialty medical board certification. Recertification may be provided by a medical professional organization, such as one or more of the medical specialty boards of the American board of medical specialties, the American osteopathic association, the national board of physicians and surgeons, or any other ~~alternative, regulated~~ board a credentialing entity recognizes.
   c. "Physician" means a physician licensed under chapter 43-17.
   d. "Specialty medical board certification" means certification by a board specializing in one particular area of medicine. ~~A physician is considered a board certifiedmedical specialist in this state if the physician receives initial certification by a~~ and typically has requirements in addition to those the board requires to practice medicine

HB 1433

Attachment 2
Jan 29, 2019

~~medical board, regardless of the physician's maintenance of certification participation or status~~.

2. Except as provided in subsection 5, a physician may not be denied staff privileges or employment by a facility licensed under this chapter based solely on the physician's decision to not participate in maintenance of certification.

3. This section does not prevent a facility's credentialing committee from requiring a physician meet continuing medical education requirements as set by the physician's licensing board.

4. This section does not prohibit a facility licensed under this chapter from requiring a physician to undergo remedial or corrective courses or training as may be required by a quality improvement committee.

5. A facility licensed under this chapter may differentiate between physicians based on a physician's maintenance of certification if:

a. The facility's designation, certification, or accreditation is contingent on the facility requiring a specific maintenance of certification by physicians seeking staff privileges or credentialing at the facility and the differentiation is limited to those physicians whose maintenance of certification is required for the facility's designation, certification, or accreditation; or

b. The voting physician members of the facility's organized medical staff vote to authorize the differentiation and the facility's governing body approves the vote.

~~(1) The authorized differentiation may be made only by the voting physician members of the facility's organized medical staff and not by the facility's governing body, administration, or any other person~~.

~~(2)~~ (1) The facility may establish terms applicable to the facility's differentiation, including appropriate grandfathering provisions, ~~limiting the differentiation to certain medical specialties~~, and allowing the differentiation to be rescinded at any time by a vote of the voting physician members of the facility's organized medical staff.

(2) Nothing in this provision shall be construed to require a new vote by the facility's medical staff.

(3) Notwithstanding, nothing in this section shall be meant to abrogate or supersede an individual facility's organized medical staff and governing board to self-determine credentialing and privileging criteria with respect to board certification and the maintenance of certification requirements thereof.

6. A facility licensed under this chapter may not consider maintenance of certification participation or status as a standard of care consideration in the course of a quality improvement assessment.

HB 1433

Attachment 2
Jan 29, 2019

~~**SECTION 2.** A new section to chapter 23-34 of the North Dakota Century Code is created and enacted as follows:~~

~~**Peer review - Limitations.**~~

~~A peer review organization may not consider maintenance of certification participation or status as a standard of care consideration in the course of a professional peer review.~~

SECTION ~~3~~ 2. A new section to chapter 26.1-47 of the North Dakota Century Code is created and enacted as follows:

Maintenance of certification.

1. As used in this section, the terms "continuing medical education", "maintenance of certification", "physician", and "specialty medical board certification" have the same meaning as provided under section 1 of this Act.
2. A health care insurer may not deny reimbursement to or prevent a physician from being a preferred provider based solely on a physician's decision to not participate in maintenance of certification, including basing a physician's network participation on any form of maintenance of certification participation or status.
3. A health care insurer may not discriminate with respect to reimbursement levels based solely on a physician's decision to not participate in any form of maintenance of certification.

~~**SECTION 4.** A new section to chapter 31-04 of the North Dakota Century Code is created and enacted as follows:~~

~~**Medical-related civil action - Maintenance of certification.**~~

~~In a medical-related civil action, maintenance of certification participation or status of a physician is not admissible as evidence of liability or of standard of care.~~

SECTION ~~5~~ 3. EMERGENCY. This Act is declared to be an emergency measure.

Attachment 3
Jan 29, 2019
Page 1

Proposed amendments to SB 1433

Page 1, line 1, replace "a new section to chapter" with "and"

Page 1, line 2, remove "23-34,"

Page 1, line 2, remove "and a new section to chapter 31-04"

Page 1, line 18, remove "alternative, regulated"

Page 1, Line 22 replace ". A physician is considered a board certified medical specialist in this state if the physician receives initial certification by a" with "and typically has requirements in addition to those the North Dakota Board of Medicine requires to practice medicine."

Page 2, line 1, remove "medical board, regardless of the physician's maintenance of certification"

Page 2, line 2, remove "participation or status."

Page 2, line 20, after "differentiation", insert "and the facility's governing body approves the vote"

Page 2, remove lines 21 through 23

Page 2, line 24, replace "(2)" with "(1)"

Page 2, line 25, remove "limiting the differentiation to"

Page 2, line 26, remove "certain medical specialties"

Page 2, after line 28, insert

(2) Nothing in this provision shall be construed to require a new vote by the facility's medical staff.

(3) Notwithstanding, nothing in this section shall be meant to abrogate or supersede an individual facility's organized medical staff and governing board to self-determine credentialing and privileging criteria with respect to board certification and the maintenance of certification requirements thereof.

Page 3, remove lines 1 through 5

Page 3, line 6, replace "3" with "2"

Page 3, remove lines 19 through 23

Page 3, line 24, replace "5" with "3"

Renumber accordingly

HB 1433

Attachment 4
Jan 29, 2019
Page 1

January 18, 2010

Sir:

I am disenchanted with the Maintenance of Certification (MOC) test. I will go so far as to say the test is a farce and an affront to many of us who took re-certification seriously. Let me explain by recounting my personal experience with the MOC written test. I took the re-certification test in 2008. I had studied extensively for it. I studied from several textbooks as well an older version of the DVD study guide put out by ASPS. I spent a greater portion of the time on the textbooks, but also reviewed many of the questions in the DVD study guide. I spent more time on the hand and maxillofacial modules as I felt this was an area which required more preparation. Because I took this exam seriously, I spent many hours in preparation. I was quite disappointed when the results came back and found that I had not attained a passing score. My score was 72%. This was not surprising as I was expecting a score in the mid seventies, consistent with what I may have expected in previous national standardized testing. What surprised me was that the mean score was 91%, and further, that only 4% had "failed" the test. I pondered this confusing situation, as never before had I seen a mean score so high, nor my results in such a low percentile. The only solution I could surmise was that the test questions were taken directly from the study guide. This would account for the fact that during the test I thought I had recognized a few questions from the study guide. It would also account for such an extraordinarily high mean test score. I paid the additional fees to retake the test the following year and chose to purchase the new study guide. I studied nothing more than comprehensive module of the recommended study guide sold by ASPS. I took the test and received a score of 100. When I came upon questions which had pictures, I was actually able to answer correctly without even reading the question, knowing that each picture had a given answer in the study guide. In the comment section at the completion of the test I had indicated that I was frustrated in my finding and felt that the test was a sham. I invited those involved in preparing the test to contact me for further discussion, but that didn't happen.

I am extraordinarily frustrated by the process, by the American Society of Plastic Surgeons, and by the American Board of Plastic Surgery in their involvement with the production of this test. My frustration comes from two avenues. The first is that a great deal of my time and effort has been wasted in taking a test which has no value in assessing my competence as a surgeon. I'm frustrated by the fact that I am essentially held hostage to a process which extorts significant fees and demands that I jump through multiple hoops in order that I may maintain a certification for which I had previously worked extremely hard. Secondly, I am frustrated that this process diminishes and demeans the certification which I have earned. Putting forth a test in which a high school kid with a decent memory could get a passing score has no value as a means of assessing my competence as a plastic surgeon. I do, however, see that it is a public relations maneuver. We say that ABPS and ASPS require maintenance of certification, making the public feel that we maintain a degree of competency throughout our careers by the several methods currently in place in the MOC process.

I propose to you that much of this process is needlessly weighted down with bureaucracy and inefficiency. The MOC re-certification process appears to be afflicted with the same ailment seen in many institutions today. That is, we throw out common sense for the sake of appearances. We want to put certain parameters in place because it sounds good. We do this without asking, what the purpose and value are. My understanding is that the aim is to ensure a certain level of competency in order that the branding of being a board certified plastic surgeon continues to carry value and meaning to the public as well as to the diplomates. We need to accept that there are limitations to which centralized procedures can ensure this. We must trust that the training and requirements set forth to obtain the initial certification have allowed for the foundation of a well-equipped surgeon throughout his or her career. The means of assuring basic competency are easily assessed by such simple things as CME requirements, assessment of liability history, and assessment of hospital privileges. We don't need to have the extra hoops, the time consuming requirements, the meaningless test, or the fee-inducing bureaucracy.

The purpose of the test is to confirm that the successful examinee is of such knowledge and competence that he or she is deemed to be of the level of a highly educated board certified plastic surgeon, yet my high school student, given incentive, would pass this test with ease. Clearly the integrity of this process has been lost.

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Attachment 5

House Industry Business and Labor Committee
HB 1433
January 29, 2019

Chairman Keiser, Members of the committee thank you for allowing me to testify on HB 1433 today.

My name is Fadel Nammour, I am a gastroenterologist with an established practice in Fargo. I am board certified x2, and recertified x2 and currently still under the status of "participating in maintenance of certification" through the American Board of Internal Medicine, but also recertified through the National Board of Physicians and Surgeons. I am immediate past governor for the American College of Gastroenterology for ND and the governor elect for the American College of Physicians for ND.

I am testifying today on behalf of the North Dakota Medical Association, which I have the privilege of being its current president. I am testifying in support of HB 1433. My testimony will focus on the history behind this bill and why it's an important step for patient care and access in the state of ND and nationwide.

"Nothing has yet been said that's not been said before." I am not reinventing the wheel. This has been debated since 2014 and all the information presented is readily available to the public.

The American board of medical specialty created in the early 1930s is a private, not for profit organization, currently with a 24-member board including the American board of Internal Medicine which set standards and assess physician knowledge and skills. As a gastroenterologist ABIM is the board that oversees my board certification.

"Board certification" is a valued credential recognized by not only the United States physicians and public but worldwide. I came from Lebanon to be an American Board-certified physician. It is and should be a mark of distinction after years of effort through medical school, multiple testing (USMLE step 1,2 and 3) training and passing a 2 days high stake examination.

In 1990, the ABIM restricted board certification to a 10 year, "time limited" certificate. To retain the credential, physicians must comply with ABIM

Maintenance of Certification or MOC. And that's how the story begins. The process included a (re)certification test every 10 years, and various activities to earn MOC points. Physicians certified before the 1990 examination were "grandfathered" meaning they had "time-unlimited" certification and did not need to participate in any MOC activity to maintain their credentials.

In 2014, "the year of the revolution", ABIM decided to change the process, doubling the number of MOC points, changing the type of points and the time frame which they had to be earned. They also changed physician status on their website to board certified "meeting" or "not meeting" MOC requirement. While the enrollment fees have been slowly creeping up with an increase around 16-17% / year from 2000 to 2014.

Many physicians were appalled by these changes and petitions were circulated (signed by 22, 000 respondents) requesting a recall of MOC process. This movement spearheaded by Dr Teirstein (a cardiologist) and highlighted the futility of many aspects of ABIM MOC and exposed the financial scandals surrounding the Board and its members with exorbitant salaries, condominium purchases, funneling money to Cayman Islands and to the ABIM foundation. Even a change in bylaws in 1998 allowed ABIM board to have unlimited conflicts, with section 9-5. "The board may accept gifts, grants, devices or bequests of funds or any other property from any public or governmental body or any private person, including private and public foundations, corporations, and individuals, for its corporate purposes."

The debate spilled over to the general public with Newsweek Magazine articles titled "The ugly civil war in American Medicine" describing the divide between the boards and physicians.

In 2015, ABIM responded by suspending the Practice Assessment modules, freezing increases in Enrollment fees, changing the online status credential to "participation or not participating" in MOC instead of "meeting or not meeting", but kept the high-stakes examination.

That same year Dr. Teirstein created the National Board of Physicians and Surgeons as an alternative to maintaining board certification without using the MOC trademark. Board members are well respected physicians from across the nation that value patient, research and lifelong learning. None of them are

compensated. This board acknowledges the importance of initial certification through ABMS.

Candidates for recertification through the NBPAS have to meet the following criteria:

- Must have been certified by an ABMS board
- Must have unrestricted license to practice in at least one state
- Must complete 50 hours of Continuous Medical Education (CME) within the past 24 months
- Cost for initial recertification $169 (MD) and $189 (DO), for renewal $145 (MD) and $165 (DO)

Why CME?

- CME is regulated by a rigorous accreditation body, the Accreditation Council for Continuing Medical Education (ACCME).
- CME provides education in both established knowledge and future directions in a more dynamic and up to date manner keeping physicians on the "cutting edge"
- CME needs to meet performance standers including speakers' conflict of interest, course evaluation, educational gap analysis and so forth.
- CME is already required by state medical board licensure and would avoid unnecessary duplication
- CME programs are provided by multiple organization which stimulates competition and continuous improvement therefore offers more choices, in stark contrast with ABIM's monopoly on MOC.

In September 2018, the Department of Justice issued an opinion about MOC citing it may have the effect of "harming competition and increasing the cost of healthcare services to customers."

After all is said and done, our main purpose is patient care access and outcome. We are strong proponents of lifelong learning concept, but we oppose the current process to achieve it. Physician – patient relationship is at stake. The administrative burden is immense and jeopardizes care. What we have been doing is not working. "Less is more." Let's give our physicians more time to spend with their patients and less regulation.

HB 1433

Attachment 5
Jan 29, 2019

Studies and data presented by ABMS as compelling evidence of the benefits of MOC are at best ambiguous if not negative for the state of our healthcare.

An independent Vision for the future Commission, established by the ABMS released a draft report highlighting the deficiency of MOC and possible remediation. Going as far as abandoning the term "MOC" and adopting "a new term that communicates the concept, intentions, and expectations of future continuing certification programs".

- Only one of ten physicians value MOC
- The evidence correlating MOC to patient outcomes is inconclusive
- The content of the examination was not relevant and was not the reflection of the application of knowledge in the clinical environment and was not current with advances in medicine.
- MOC can harm physicians and recommends that ABMS inform hospitals and healthcare organization that ongoing certification should not be used as the only criteria for credentialing and privileges.

What was once considered a "voluntary continuous professional development accolade" has become a burdensome, irrelevant and expensive endeavor affecting patient care.

I urge you to support this bill, let common sense, less regulation and freedom of choice prevail not only in government and business but also in healthcare. Protect ND physicians' right to work. Let this be a message of support to your medical workforce who works hard in the trenches providing higher quality of care at lower cost than many other states and an opportunity to increase physician recruitment and retention.

I'd be happy to answer any questions.

Attachment 6

House Industry Business and Labor Committee
HB 1433
January 29, 2019

Chairman Keiser and members of the committee, I want to express my full support of Dr. Fadel Nammour's testimony on HB 1433. Dr. Nammour is an excellent physician and leader for the NDMA. My name is Tom Strinden, I am a third generation North Dakotan with an established Ophthalmology practice based in Fargo. I graduated from the UND School of Medicine in 1988 and was born in Grand Forks. I have served as a volunteer UNDSM Associate Clinical Professor since 1995. I am a past President of the North Dakota Society of Eye Physicians and Surgeons (NDSEPS). I served two terms representing North Dakota on the Council of the American Academy of Ophthalmology. I am speaking on behalf of the NDSEPS and the NDMA. I am currently the Political Action Committee Chair for both organizations.

I am board certified in Ophthalmology by the American Board of Ophthalmology-ABO (Subspecialty board of the American Board of Medical Specialties-ABMS) and the National Board of Physicians and Surgeons (NBPAS). My subspecialty board granted lifetime board certificates to anyone that finished their Ophthalmology training by 1988. This group had until 1994 to pass the written and oral boards. I successfully completed my boards in 1994 sitting next to those whose board certificate had no limit. This obviously didn't seem fair and when I complained to the ABO they assured me that the recertification test would be an open book take home test. In 2004, I paid a substantial fee and successfully took the take home test. I at the same time took and passed a test to be certified by the National Board of Ophthalmology.

I am one of 130 Ophthalmologists that are certified by a board founded by a then little-known Eye Surgeon from Kentucky, Rand Paul. Both of these tests consumed a considerable amount of my valuable family time and provided little value to me or my Patients. My experience with the ABO MOC continued to change with many more time-consuming requirements added. Four years ago, I passed my board test for the third time. The three-section test took most of my day and was administered at a proctored testing center in Fargo. The current MOC 2.0(mini-quizzes) are more time consuming, equally expensive, and are unproven to provide any benefit. The test can be taken over and over until passed.

HB 1433

Attachment 6
Jan 29, 2019

Why do we want ND to become a right to work state for Physicians?

1. 12 states have passed some form of board certification reform legislation
2. 30-40% of US Physicians are experiencing "Burnout" JAMA 2011;305(19): 2009-2010
3. For Every 1 hour of patient care there is 2 hours of time spent on the electronic health record (EHR). AMA study
   The average Physician spends 90+ minutes in the Evening completing EHR documentation
4. Looming Physician shortage: By 2030 there is a projected shortage of between 42,600 – 121,300 Physicians. Primary Care shortage 14,800-49,300 and 33,800 – 72,700 Specialty Providers. April 11, 2018 Press Release Association of American Medical Colleges
5. Nationally over 1/3 of the active Physicians will be over 65 by 2030
6. The National Population over 65 will double by 2030
7. North Dakota has the oldest nursing home residents with 46% age 85-95 years, (highest in the nation - US Average is 31% in this age category), and 8.7% over age 95, (second highest in the nation – US average is 5% in this age category). Senate Bill 2012 Health and Human Services NDLTCA Testimony 2019 session.

Chairman Keiser and members of the IBL Committee, I ask for your support of HB 1433. Passing this legislation will help North Dakota to retain and recruit physicians to our great State. I am proud that North Dakota is a right to work state. Your passing this bill will allow Physicians to practice unencumbered by the expensive, time consuming and unproven MOC testing. Thank you and I am happy to answer any questions.

NDMA
Est.1887 NORTH DAKOTA MEDICAL ASSOCIATION

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Attachment 6
Jan 29, 2019
Page 3

Physicians Dedicated to the Health of North Dakota

NDMA is the professional membership organization for North Dakota physicians, residents, and medical students. NDMA maintains a database of information on individual physicians and residents for many purposes. Our data is comprised of new licensure information obtained routinely from the ND Board of Medicine, health systems and other facilities, and other sources. Here is a summary of essential demographics.

Number of Physicians

Overall, there are 1681 regular active physicians in North Dakota at 2018 year-end – this does not include retired physicians, residents or medical students.

UNDSMHS Graduates

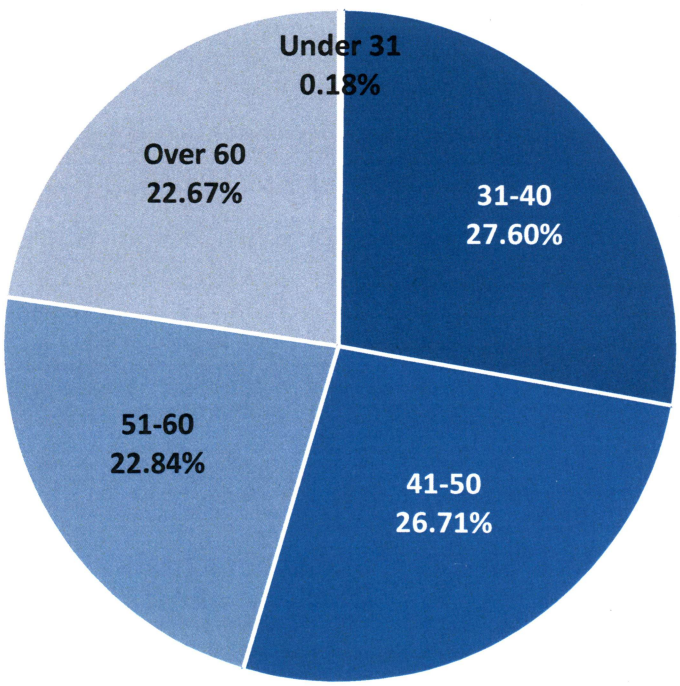
Of the total physicians, 592 are graduates of the UND School of Medicine and Health Sciences. 300 of the 592 are in a primary care practice.

Gender and Age of Physicians

Of the 1681 physicians, 1167 or 69.42% are men; 514 or 30.58% are women.

The overall average age of physicians is 50, with the breakdown by age group as follows:

Age	Number	% of Total	Age	Number	% of Total
Under 31	3	0.18%	51-60	384	22.84%
31-40	464	27.60%	Over 60	381	22.67%
41-50	449	26.71%	Total	1681	100.00%



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Specialty - Primary Care

Of the 1681 total physicians, 35% or 596 physicians are in primary care. For this purpose, we define primary care as family medicine, general practice, internal medicine, obstetrics, and pediatrics.

North Dakota Practicing Physicians by Specialty as of 12/31/18
(First Self-Designated Specialty Only)

	Specialty	Count	%		Specialty	Count	%
AI	**Allergy & Immunology**	7	0.42%	OBG	**Obstetrics & Gynecology**	77	4.58%
PTH	**Anatomic /Clinical Pathology**	38	2.26%	OM	**Occupational Medicine**	2	0.12%
AN	**Anesthesiology**	87	5.18%	ON	**Oncology**	12	0.71%
CAE	**Cardiac Electrophysiology**	3	0.18%	OPH	**Ophthalmology**	37	2.20%
CTS	**Cardiothoracic Surgery**	2	0.12%	ORS	**Orthopaedic Surgery**	60	3.57%
CD	**Cardiovascular Disease**	35	2.08%	OTR	**Orthopaedic Trauma**	2	0.12%
CDS	**Cardiovascular Surgery**	7	0.42%	OTO	**Otolaryngology**	27	1.61%
CHP	**Child and Adolescent Psychiatry**	7	0.42%	APM	**Pain Medicine (Anesthesiology)**	6	0.36%
CHN	**Child Neurology**	1	0.06%	PMP	**Pain Medicine (Physical Med & Rehab)**	1	0.06%
CLP	**Clinical Pathology**	1	0.06%	PLM	**Palliative Medicine**	1	0.06%
CRS	**Colon & Rectal Surgery**	5	0.30%	PDA	**Pediatric Allergy**	1	0.06%
CCM	**Critical Care Medicine**	16	0.95%	PAN	**Pediatric Anesthesiology**	2	0.12%
D	**Dermatology**	22	1.31%	PDC	**Pediatric Cardiology**	4	0.24%
DMP	**Dermatopathology**	4	0.24%	CCP	**Pediatric Critical Care**	4	0.24%
DR	**Diagnostic Radiology**	57	3.39%	PDG	**Pediatric Gastroenterology**	1	0.06%
EM	**Emergency Medicine**	81	4.82%	PHO	**Pediatric Hematology/Oncology**	3	0.18%
END	**Endocrinology, Diabetes, & Metabolism**	8	0.48%	OP	**Pediatric Orthopedics**	2	0.12%
FM	**Family Medicine**	332	19.75%	PDP	**Pediatric Pulmonology**	1	0.06%
FOP	**Forensic Pathology**	1	0.06%	PDR	**Pediatric Radiology**	1	0.06%
GE	**Gastroenterology**	22	1.31%	PPR	**Pediatric Rheumatology**	1	0.06%
GS	**General Surgery**	63	3.75%	PDS	**Pediatric Surgery**	2	0.12%
GER	**Geriatrics**	3	0.18%	PD	**Pediatrics**	93	5.53%
HS	**Hand Surgery**	6	0.36%	PM	**Physical Medicine & Rehabilitation**	13	0.77%
HEM	**Hematology (Internal Medicine)**	24	1.43%	PS	**Plastic Surgery**	14	0.83%
HOS	**Hospitalist**	93	5.53%	P	**Psychiatry**	71	4.22%
ID	**Infectious Disease**	15	0.89%	PUD	**Pulmonary Disease**	12	0.71%
IM	**Internal Medicine**	94	5.59%	RO	**Radiation Oncology**	10	0.59%
IC	**Interventional Cardiology**	11	0.65%	R	**Radiology**	11	0.65%
IR	**Interventional Radiology**	10	0.59%	REC	**Reconstructive**	1	0.06%
MFM	**Maternal & Fetal Medicine**	3	0.18%	RHU	**Rheumatology**	12	0.71%
MFS	**Maxillofacial Surgery**	11	0.65%	SMI	**Sleep Medicine (Internal Medicine)**	2	0.12%
MG	**Medical Genetics**	2	0.12%	SMN	**Sleep Medicine (Psych & Neurology)**	3	0.18%
MSR	**Musculoskeletal Radiology**	1	0.06%	FSM	**Sports Medicine (Family Medicine)**	5	0.30%
NPM	**Neonatal-Perinatal Medicine**	12	0.71%	CCS	**Surgical Critical Care**	4	0.24%
NEP	**Nephrology**	19	1.13%	SO	**Surgical Oncology**	1	0.06%
NS	**Neurological Surgery**	18	1.07%	TS	**Thoracic Surgery**	2	0.12%
N	**Neurology**	28	1.67%	TRS	**Trauma Surgery**	1	0.06%
NP	**Neurophysiology**	1	0.06%	U	**Urology**	21	1.25%
NRR	**NeuroRadiology**	1	0.06%	VS	**Vascular Surgery**	4	0.24%
NM	**Nuclear Medicine**	1	0.06%		**Total**	1681	100.00%
NR	**Nuclear Radiology**	2	0.12%				

HB 1433

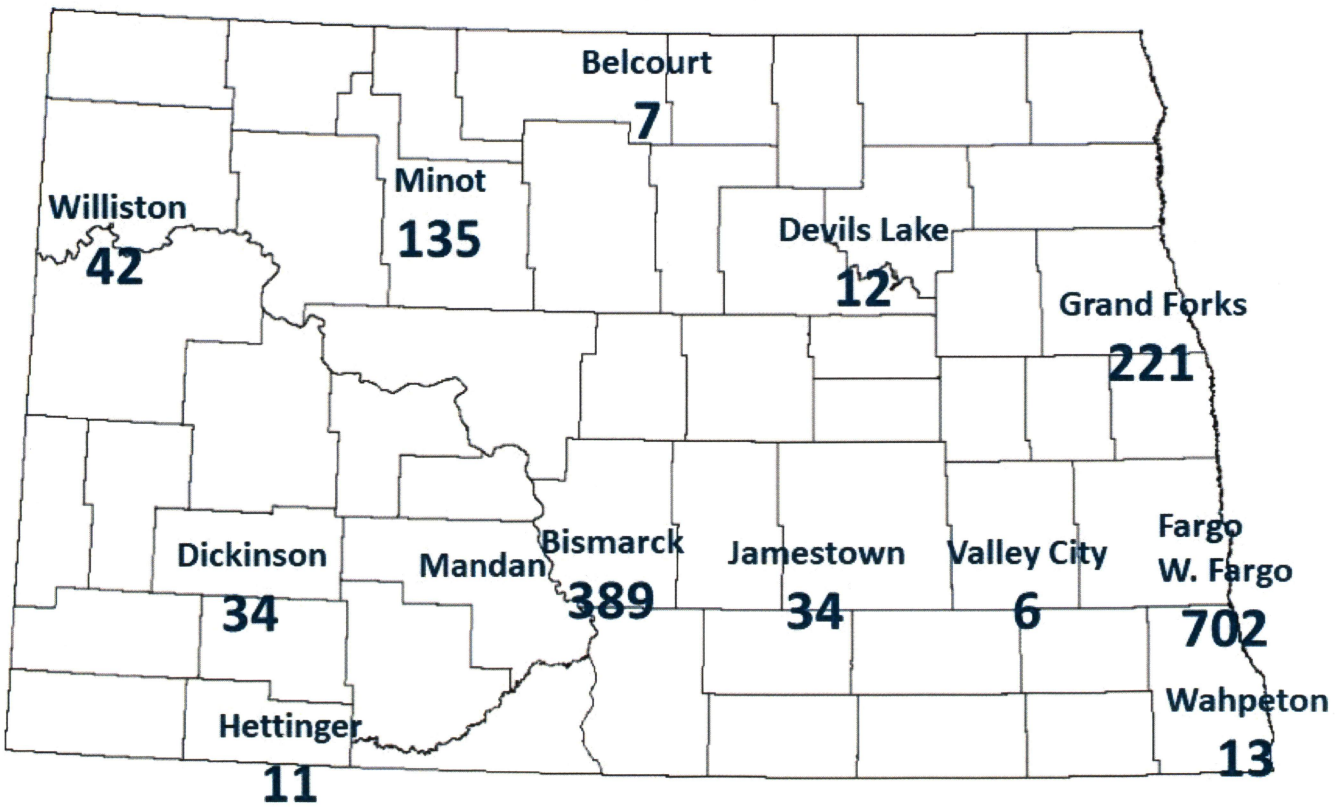
Attachment 6
Jan 29, 2019
Page 5

Practice Location

Overall, 86% of physicians (1447) practice in urban areas of the state and 14% of physicians (234) practice in rural areas. "Urban" for this purpose is based on the primary locations of Bismarck-Mandan, Fargo-West Fargo, Grand Forks and Minot. 72% of primary care physicians practice in urban areas and 28% in rural areas.

City	Count	%	City	Count	%	City	Count	%
Belcourt	7	0.42%	Gackle	1	0.06%	Minot AFB	1	0.06%
Beulah	5	0.30%	Garrison	2	0.12%	New Town	3	0.18%
Bismarck	377	22.43%	Grafton	5	0.30%	Northwood	1	0.06%
Bottineau	2	0.12%	Grand Forks	221	13.15%	Oakes	4	0.24%
Bowman	1	0.06%	Harvey	3	0.18%	Park River	3	0.18%
Carrington	1	0.06%	Hazen	2	0.12%	Pettibone	1	0.06%
Casselton	1	0.06%	Hettinger	11	0.65%	Rolla	3	0.18%
Cavalier	3	0.18%	Hillsboro	2	0.12%	Rugby	5	0.30%
Crosby	1	0.06%	Horace	2	0.12%	Stanley	1	0.06%
Devils Lake	12	0.71%	Jamestown	34	2.02%	Tioga	1	0.06%
Dickinson	34	2.02%	Langdon	1	0.06%	Trenton	1	0.06%
Dunseith	2	0.12%	Lisbon	2	0.12%	Valley City	6	0.36%
Elgin	1	0.06%	Mandan	12	0.71%	Wahpeton	13	0.77%
Enderlin	1	0.06%	Mayville	2	0.12%	Watford City	3	0.18%
Fargo	692	41.17%	McVille	2	0.12%	West Fargo	10	0.59%
Fort Totten	2	0.12%	Michigan	1	0.06%	Williston	42	2.50%
Fort Yates	3	0.18%	Minot	135	8.03%		1681	100.00%

North Dakota Practicing Physicians by City*



*Cities with six or more physicians only.

NDMA

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3-4-19
#1 pg. 1

#1

January 18, 2010

Sir:

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#1 pg. 2

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HB 1433
3-4-19
#2 pg. 1

NDMA
Est.1887 NORTH DAKOTA MEDICAL ASSOCIATION

Senate Industry Business and Labor Committee
HB 1433
March 4, 2019

Good morning Chairman Klein and Committee Members. I am Courtney Koebele and I serve as executive director of the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents, and medical students.

HB 1433 is one of many bills that have been filed and passed throughout the country regarding a growing controversy – Maintenance of Certification (MOC). Almost a dozen states have passed laws, and many more have pending bills this legislative session. Most recently, Michigan passed a bill last month that prohibits the use of MOC for certain specialties.

What is MOC? After physicians complete their residency, they may choose to take a certification exam by one of the several boards governed by the American Board of Medical Specialties (ABMS). This initial board certification must be maintained through a series of the tests and other activities called MOC. No medical board in the country requires specialty certification for licensure or MOC for licensure.

This bill arose out of concerns expressed by many physicians regarding the costs and efficacy of testing required for MOC by national

medical specialty certification boards, as well as concerns about the use or potential use of MOC by insurance plans and health care facilities as a "de facto mandate on physicians."

NDMA passed a resolution last year regarding MOC as follows:

1. That NDMA acknowledge that the requirements within the Maintenance of Certification process are costly and time intensive, and they result in significant disruptions to the availability of physicians for patient care.

2. That NDMA acknowledge that after initial specialty board certification, the NDMA affirms the professionalism of the physician to pursue the best means and methods for maintenance and development of their knowledge and skills.

3. That NDMA reaffirms and encourages the value of continuing medical education, while opposing mandatory Maintenance of Certification as a requirement for licensure, hospital privileges, and reimbursement from third party payers.

This bill does not limit the use of initial board certification for credentialing, nor is it in any way a statement in support of less learning by physicians or reduced quality of care. This bill allows more choice for physicians and in some states it's called a "right to work" act.

HB 1433 puts definitions into the century code about maintenance of certification and allows for a Hospital's medical staff to choose whether it will require maintenance of certification. HB 1433 would prohibit the use of maintenance of certification (MOC) as the sole basis for health insurance plan reimbursement and/or credentialing.

I plan on stepping through the bill and have a couple of members that will explain the history of the issue, and why it's a good idea for North

Dakota to pass this bill. We have been working with interested stakeholders and the bill was amended in the House.

The first section of the bill defines continuing medical education, maintenance of certification, physician and specialty medical board certification.

The next part of the bill prohibits hospitals from using MOC, except through section 5.

On page 2, line 7, section 5 details the exception for the facility to allow differentiation. This section allows the facility to differentiate if their designation is contingent on their physicians maintaining certification, or if its medical staff votes to differentiate, and it is approved by its governing board. Nothing in the section is construed to require a new vote by the medical staff. Nothing in the section is meant to abrogate or supersede an individual facility's organized medical staff and governing board to self-determine credentialing and privileging.

Finally, section 2 of the bill prohibits a health care insurer to deny reimbursement to or prevent a physician from being a preferred provider based solely on a physician's decision to not participate in MOC, and it may not discriminate with respect to reimbursement levels based solely on a physician's decision to not participate in MOC.

Thank you for your time today. NDMA would urge a DO PASS, on HB 1433. I would like to introduce Fadel Nammour, MD and Thomas Strinden, MD, who will be following me, and explain in more detail the background of MOC, and why we are supporting this bill. I would be happy to answer any questions.

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House Industry Business and Labor Committee
HB 1433
March 4, 2019

Chairman Klein, Members of the committee thank you for allowing me to testify on HB 1433 today.

My name is Fadel Nammour, I am a gastroenterologist with an established practice in Fargo. I am board certified x2, and recertified x2 and currently still under the status of "participating in maintenance of certification" through the American Board of Internal Medicine, but also recertified through the National Board of Physicians and Surgeons. I am immediate past governor for the American College of Gastroenterology for ND and the governor elect for the American College of Physicians for ND.

I am testifying today on behalf of the North Dakota Medical Association, which I have the privilege of being its current president. I am testifying in support of HB 1433. My testimony will focus on the history behind this bill and why it's an important step for patient care and access in the state of ND and nationwide.

"Nothing has yet been said that's not been said before." I am not reinventing the wheel. This has been debated since 2014 and all the information presented is readily available to the public.

The American board of medical specialty created in the early 1930s is a private, not for profit organization, currently with a 24-member board including the American board of Internal Medicine which set standards and assess physician knowledge and skills. As a gastroenterologist ABIM is the board that oversees my board certification.

"Board certification" is a valued credential recognized by not only the United States physicians and public but worldwide. I came from Lebanon to be an American Board-certified physician. It is and should be a mark of distinction after years of effort through medical school, multiple testing (USMLE step 1,2 and 3) training and passing a 2 days high stake examination.

In 1990, the ABIM restricted board certification to a 10 year, "time limited" certificate. To retain the credential, physicians must comply with ABIM

Maintenance of Certification or MOC. And that's how the story begins. The process included a (re)certification test every 10 years, and various activities to earn MOC points. Physicians certified before the 1990 examination were "grandfathered" meaning they had "time-unlimited" certification and did not need to participate in any MOC activity to maintain their credentials.

In 2014, "the year of the revolution", ABIM decided to change the process, doubling the number of MOC points, changing the type of points and the time frame which they had to be earned. They also changed physician status on their website to board certified "meeting" or "not meeting" MOC requirement. While the enrollment fees have been slowly creeping up with an increase around 16-17% / year from 2000 to 2014.

Many physicians were appalled by these changes and petitions were circulated (signed by 22, 000 respondents) requesting a recall of MOC process. This movement spearheaded by Dr Teirstein (a cardiologist) and highlighted the futility of many aspects of ABIM MOC and exposed the financial scandals surrounding the Board and its members with exorbitant salaries, condominium purchases, funneling money to Cayman Islands and to the ABIM foundation. Even a change in bylaws in 1998 allowed ABIM board to have unlimited conflicts, with section 9-5. "The board may accept gifts, grants, devices or bequests of funds or any other property from any public or governmental body or any private person, including private and public foundations, corporations, and individuals, for its corporate purposes."

The debate spilled over to the general public with Newsweek Magazine articles titled "The ugly civil war in American Medicine" describing the divide between the boards and physicians.

In 2015, ABIM responded by suspending the Practice Assessment modules, freezing increases in Enrollment fees, changing the online status credential to "participation or not participating" in MOC instead of "meeting or not meeting", but kept the high-stakes examination.

That same year Dr. Teirstein created the National Board of Physicians and Surgeons as an alternative to maintaining board certification without using the MOC trademark. Board members are well respected physicians from across the nation that value patient, research and lifelong learning. None of them are

compensated. This board acknowledges the importance of initial certification through ABMS.

Candidates for recertification through the NBPAS have to meet the following criteria:

- Must have been certified by an ABMS board
- Must have unrestricted license to practice in at least one state
- Must complete 50 hours of Continuous Medical Education (CME) within the past 24 months
- Cost for initial recertification $169 (MD) and $189 (DO), for renewal $145 (MD) and $165 (DO)

Why CME?

- CME is regulated by a rigorous accreditation body, the Accreditation Council for Continuing Medical Education (ACCME).
- CME provides education in both established knowledge and future directions in a more dynamic and up to date manner keeping physicians on the "cutting edge"
- CME needs to meet performance standers including speakers' conflict of interest, course evaluation, educational gap analysis and so forth.
- CME is already required by state medical board licensure and would avoid unnecessary duplication
- CME programs are provided by multiple organization which stimulates competition and continuous improvement therefore offers more choices, in stark contrast with ABIM's monopoly on MOC.

In September 2018, the Department of Justice issued an opinion about MOC citing it may have the effect of "harming competition and increasing the cost of healthcare services to customers."

After all is said and done, our main purpose is patient care access and outcome. We are strong proponents of lifelong learning concept, but we oppose the current process to achieve it. Physician – patient relationship is at stake. The administrative burden is immense and jeopardizes care. What we have been doing is not working. "Less is more." Let's give our physicians more time to spend with their patients and less regulation.

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Studies and data presented by ABMS as compelling evidence of the benefits of MOC are at best ambiguous if not negative for the state of our healthcare.

An independent Vision for the future Commission, established by the ABMS released a draft report highlighting the deficiency of MOC and possible remediation. Going as far as abandoning the term "MOC" and adopting "a new term that communicates the concept, intentions, and expectations of future continuing certification programs".

- Only one of ten physicians value MOC
- The evidence correlating MOC to patient outcomes is inconclusive
- The content of the examination was not relevant and was not the reflection of the application of knowledge in the clinical environment and was not current with advances in medicine.
- MOC can harm physicians and recommends that ABMS inform hospitals and healthcare organization that ongoing certification should not be used as the only criteria for credentialing and privileges.

What was once considered a "voluntary continuous professional development accolade" has become a burdensome, irrelevant and expensive endeavor affecting patient care.

I urge you to support this bill, let common sense, less regulation and freedom of choice prevail not only in government and business but also in healthcare. Protect ND physicians' right to work. Let this be a message of support to your medical workforce who works hard in the trenches providing higher quality of care at lower cost than many other states and an opportunity to increase physician recruitment and retention.

I'd be happy to answer any questions.

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Senate Industry Business and Labor Committee
HB 1433
March 4, 2019

Chairman Klein and members of the committee, I want to express my full support of Dr. Fadel Nammour's testimony on HB 1433. Dr. Nammour is an excellent physician and leader for the NDMA. My name is Tom Strinden, I am a third generation North Dakotan with an established Ophthalmology practice based in Fargo. I graduated from the UND School of Medicine in 1988 and was born in Grand Forks. I have served as a volunteer UNDSM Associate Clinical Professor since 1995. I am a past President of the North Dakota Society of Eye Physicians and Surgeons (NDSEPS). I served two terms representing North Dakota on the Council of the American Academy of Ophthalmology. I am speaking on behalf of the NDSEPS and the NDMA. I am currently the Political Action Committee Chair for both organizations.

I am board certified in Ophthalmology by the American Board of Ophthalmology-ABO (Subspecialty board of the American Board of Medical Specialties-ABMS) and the National Board of Physicians and Surgeons (NBPAS). My subspecialty board granted lifetime board certificates to anyone that finished their Ophthalmology training by 1988. This group had until 1994 to pass the written and oral boards. I successfully completed my boards in 1994 sitting next to those whose board certificate had no limit. This obviously didn't seem fair and when I complained to the ABO they assured me that the recertification test would be an open book take home test. In 2004, I paid a substantial fee and successfully took the take home test. I at the same time took and passed a test to be certified by the National Board of Ophthalmology.

I am one of 130 Ophthalmologists that are certified by a board founded by a then little-known Eye Surgeon from Kentucky, Rand Paul. Both of these tests consumed a considerable amount of my valuable family time and provided little value to me or my Patients. My experience with the ABO MOC continued to change with many more time-consuming requirements added. Four years ago, I passed my board test for the third time. The three-section test took most of my day and was administered at a proctored testing center in Fargo. The current MOC 2.0(mini-quizzes) are more time consuming, equally expensive, and are unproven to provide any benefit. The test can be taken over and over until passed.

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Why do we want ND to become a right to work state for Physicians?

1. 12 states have passed some form of board certification reform legislation
2. 30-40% of US Physicians are experiencing "Burnout" JAMA 2011;305(19): 2009-2010
3. For Every 1 hour of patient care there is 2 hours of time spent on the electronic health record (EHR). AMA study
   The average Physician spends 90+ minutes in the Evening completing EHR documentation
4. Looming Physician shortage: By 2030 there is a projected shortage of between 42,600 – 121,300 Physicians. Primary Care shortage 14,800-49,300 and 33,800 – 72,700 Specialty Providers. April 11, 2018 Press Release Association of American Medical Colleges
5. Nationally over 1/3 of the active Physicians will be over 65 by 2030
6. The National Population over 65 will double by 2030
7. North Dakota has the oldest nursing home residents with 46% age 85-95 years, (highest in the nation - US Average is 31% in this age category), and 8.7% over age 95, (second highest in the nation – US average is 5% in this age category). Senate Bill 2012 Health and Human Services NDLTCA Testimony 2019 session.

Chairman Klein and members of the IBL Committee, I ask for your support of HB 1433. Passing this legislation will help North Dakota to retain and recruit physicians to our great State. I am proud that North Dakota is a right to work state. Your passing this bill will allow Physicians to practice unencumbered by the expensive, time consuming and unproven MOC testing. Thank you and I am happy to answer any questions.

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Physicians Dedicated to the Health of North Dakota

NDMA is the professional membership organization for North Dakota physicians, residents, and medical students. NDMA maintains a database of information on individual physicians and residents for many purposes. Our data is comprised of new licensure information obtained routinely from the ND Board of Medicine, health systems and other facilities, and other sources. Here is a summary of essential demographics.

Number of Physicians

Overall, there are 1681 regular active physicians in North Dakota at 2018 year-end – this does not include retired physicians, residents or medical students.

UNDSMHS Graduates

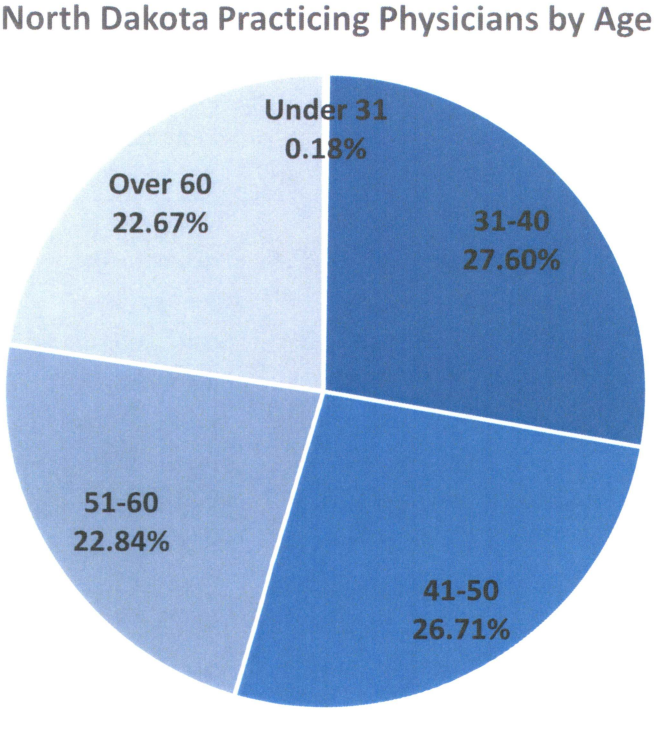
Of the total physicians, 592 are graduates of the UND School of Medicine and Health Sciences. 300 of the 592 are in a primary care practice.

Gender and Age of Physicians

Of the 1681 physicians, 1167 or 69.42% are men; 514 or 30.58% are women.

The overall average age of physicians is 50, with the breakdown by age group as follows:

Age	Number	% of Total	Age	Number	% of Total
Under 31	3	0.18%	**51-60**	384	22.84%
31-40	464	27.60%	**Over 60**	381	22.67%
41-50	449	26.71%	**Total**	1681	100.00%



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Specialty - Primary Care

Of the 1681 total physicians, 35% or 596 physicians are in primary care. For this purpose, we define primary care as family medicine, general practice, internal medicine, obstetrics, and pediatrics.

North Dakota Practicing Physicians by Specialty as of 12/31/18
(First Self-Designated Specialty Only)

	Specialty	Count	%		Specialty	Count	%
AI	Allergy & Immunology	7	0.42%	OBG	Obstetrics & Gynecology	77	4.58%
PTH	Anatomic /Clinical Pathology	38	2.26%	OM	Occupational Medicine	2	0.12%
AN	Anesthesiology	87	5.18%	ON	Oncology	12	0.71%
CAE	Cardiac Electrophysiology	3	0.18%	OPH	Ophthalmology	37	2.20%
CTS	Cardiothoracic Surgery	2	0.12%	ORS	Orthopaedic Surgery	60	3.57%
CD	Cardiovascular Disease	35	2.08%	OTR	Orthopaedic Trauma	2	0.12%
CDS	Cardiovascular Surgery	7	0.42%	OTO	Otolaryngology	27	1.61%
CHP	Child and Adolescent Psychiatry	7	0.42%	APM	Pain Medicine (Anesthesiology)	6	0.36%
CHN	Child Neurology	1	0.06%	PMP	Pain Medicine (Physical Med & Rehab)	1	0.06%
CLP	Clinical Pathology	1	0.06%	PLM	Palliative Medicine	1	0.06%
CRS	Colon & Rectal Surgery	5	0.30%	PDA	Pediatric Allergy	1	0.06%
CCM	Critical Care Medicine	16	0.95%	PAN	Pediatric Anesthesiology	2	0.12%
D	Dermatology	22	1.31%	PDC	Pediatric Cardiology	4	0.24%
DMP	Dermatopathology	4	0.24%	CCP	Pediatric Critical Care	4	0.24%
DR	Diagnostic Radiology	57	3.39%	PDG	Pediatric Gastroenterology	1	0.06%
EM	Emergency Medicine	81	4.82%	PHO	Pediatric Hematology/Oncology	3	0.18%
END	Endocrinology, Diabetes, & Metabolism	8	0.48%	OP	Pediatric Orthopedics	2	0.12%
FM	Family Medicine	332	19.75%	PDP	Pediatric Pulmonology	1	0.06%
FOP	Forensic Pathology	1	0.06%	PDR	Pediatric Radiology	1	0.06%
GE	Gastroenterology	22	1.31%	PPR	Pediatric Rheumatology	1	0.06%
GS	General Surgery	63	3.75%	PDS	Pediatric Surgery	2	0.12%
GER	Geriatrics	3	0.18%	PD	Pediatrics	93	5.53%
HS	Hand Surgery	6	0.36%	PM	Physical Medicine & Rehabilitation	13	0.77%
HEM	Hematology (Internal Medicine)	24	1.43%	PS	Plastic Surgery	14	0.83%
HOS	Hospitalist	93	5.53%	P	Psychiatry	71	4.22%
ID	Infectious Disease	15	0.89%	PUD	Pulmonary Disease	12	0.71%
IM	Internal Medicine	94	5.59%	RO	Radiation Oncology	10	0.59%
IC	Interventional Cardiology	11	0.65%	R	Radiology	11	0.65%
IR	Interventional Radiology	10	0.59%	REC	Reconstructive	1	0.06%
MFM	Maternal & Fetal Medicine	3	0.18%	RHU	Rheumatology	12	0.71%
MFS	Maxillofacial Surgery	11	0.65%	SMI	Sleep Medicine (Internal Medicine)	2	0.12%
MG	Medical Genetics	2	0.12%	SMN	Sleep Medicine (Psych & Neurology)	3	0.18%
MSR	Musculoskeletal Radiology	1	0.06%	FSM	Sports Medicine (Family Medicine)	5	0.30%
NPM	Neonatal-Perinatal Medicine	12	0.71%	CCS	Surgical Critical Care	4	0.24%
NEP	Nephrology	19	1.13%	SO	Surgical Oncology	1	0.06%
NS	Neurological Surgery	18	1.07%	TS	Thoracic Surgery	2	0.12%
N	Neurology	28	1.67%	TRS	Trauma Surgery	1	0.06%
NP	Neurophysiology	1	0.06%	U	Urology	21	1.25%
NRR	NeuroRadiology	1	0.06%	VS	Vascular Surgery	4	0.24%
NM	Nuclear Medicine	1	0.06%		Total	1681	100.00%
NR	Nuclear Radiology	2	0.12%				

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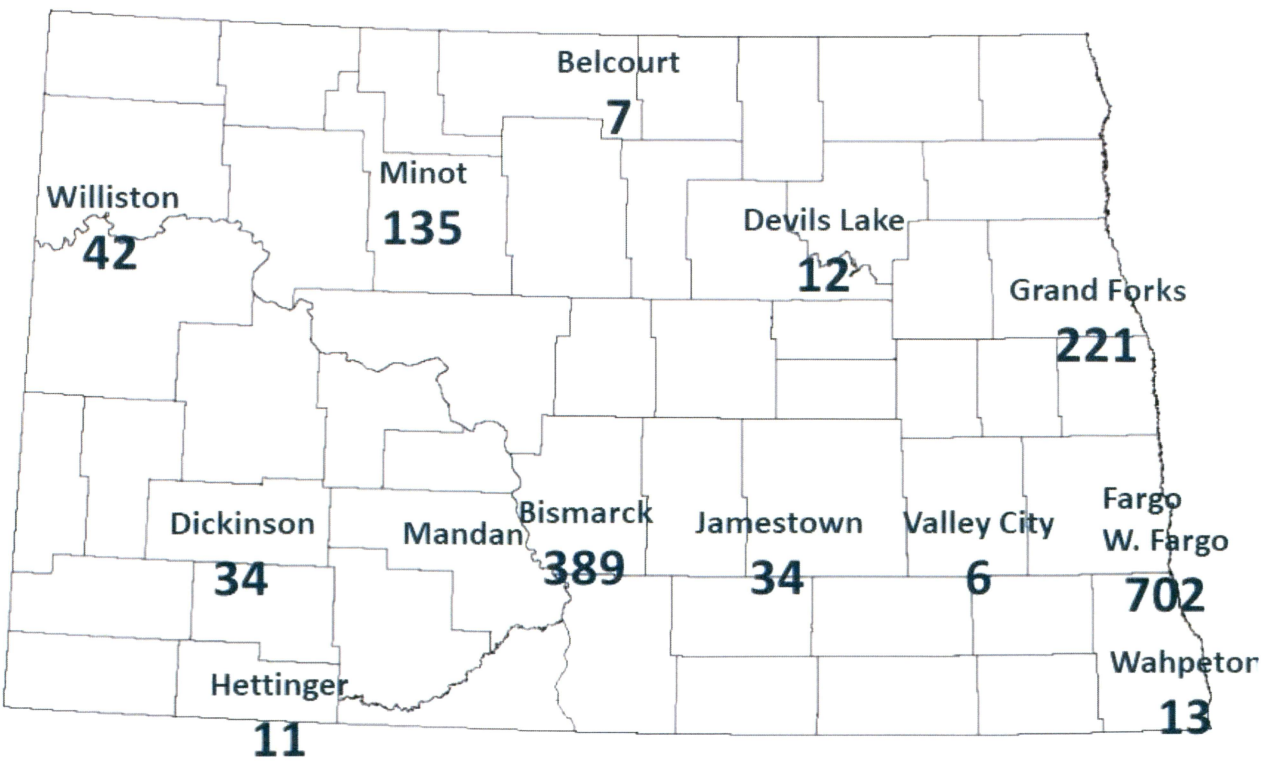
Practice Location

Overall, 86% of physicians (1447) practice in urban areas of the state and 14% of physicians (234) practice in rural areas. "Urban" for this purpose is based on the primary locations of Bismarck-Mandan, Fargo-West Fargo, Grand Forks and Minot. 72% of primary care physicians practice in urban areas and 28% in rural areas.

City	Count	%	City	Count	%	City	Count	%
Belcourt	7	0.42%	Gackle	1	0.06%	Minot AFB	1	0.06%
Beulah	5	0.30%	Garrison	2	0.12%	New Town	3	0.18%
Bismarck	377	22.43%	Grafton	5	0.30%	Northwood	1	0.06%
Bottineau	2	0.12%	Grand Forks	221	13.15%	Oakes	4	0.24%
Bowman	1	0.06%	Harvey	3	0.18%	Park River	3	0.18%
Carrington	1	0.06%	Hazen	2	0.12%	Pettibone	1	0.06%
Casselton	1	0.06%	Hettinger	11	0.65%	Rolla	3	0.18%
Cavalier	3	0.18%	Hillsboro	2	0.12%	Rugby	5	0.30%
Crosby	1	0.06%	Horace	2	0.12%	Stanley	1	0.06%
Devils Lake	12	0.71%	Jamestown	34	2.02%	Tioga	1	0.06%
Dickinson	34	2.02%	Langdon	1	0.06%	Trenton	1	0.06%
Dunseith	2	0.12%	Lisbon	2	0.12%	Valley City	6	0.36%
Elgin	1	0.06%	Mandan	12	0.71%	Wahpeton	13	0.77%
Enderlin	1	0.06%	Mayville	2	0.12%	Watford City	3	0.18%
Fargo	692	41.17%	McVille	2	0.12%	West Fargo	10	0.59%
Fort Totten	2	0.12%	Michigan	1	0.06%	Williston	42	2.50%
Fort Yates	3	0.18%	Minot	135	8.03%		1681	100.00%

North Dakota Practicing Physicians by City*



*Cities with six or more physicians only.

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