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Introducing LD 224, An Act to Strengthen Maine's Healthcare Workforce by Preventing Discrimination by Requiring Maintenance of Certification for Insurance Reimbursement

February 9, 2023

Senator Bailey, Representative Perry, esteemed committee members, thank you for hearing LD 224.

The problem that this bill seeks to improve is poor access to healthcare, especially mental and behavioral healthcare. We can see it all around us.

- Emergency rooms clogged with patients suffering from severe and persistent mental illness, in some cases literally stuck in the ER for months.
- Law enforcement officers who are asked to address mental health crises, over and over again.
- Advocates for the unhoused and homeless population identifying inadequate mental health access as a major contributor to that problem
- Just yesterday in HHS, we received a presentation from the Violence Against Health Care Workers Study in the morning, and the Augusta Mental Health Institution (AMHI) Consent Decree in the afternoon. The Director of Maine's Office of Behavioral Health Sarah Squirrell, and the Court Master for the Consent Decree former Chief Justice Daniel Wathen both focused on the *poor access to psychiatric care* as the most decisive vulnerability as it pertains to severe and persistent mental health. Chief Justice Wathen plainly said, "There just aren't enough psychiatrists throughout the state."

This bill is not a cure-all; rather it's an honest attempt to reduce one of the things that can dis-incentivize psychiatrists from moving here; starting a practice here, and staying in practice here.

So what is Maintenance of Certification (MOC)? First, let me clarify what it is not. Today we are *not* talking about removing requirements to be *licensed* to practice in Maine. Licensure will continue to have very high bars:

1. Be a graduate of an accredited, United States, or Canadian medical school (4+ years).
2. Complete at least three years of a very intense training program called a residency in a particular specialty, such as psychiatry, family medicine, or general surgery. By this point

a physician would have at least 10,000 hours of patient care, and up to 16,000 hours. Plus seemingly countless hours of academic classroom or seminar studies.

3. Pass the United States medical licensing exam or equivalent. This exam is a multi-faceted challenge involving questions and demonstrated clinical skills, like an oral board. The exam takes 4 to 5 full days to complete, in three stages.

And to *renew* a license, a physician must annually complete at least 40 hours of "Category 1" Continuing Medical Education.

None of that would be changed by this bill. *Maine's licensed allopathic and osteopathic physicians will continue to be high-quality in service to the people of our state.*

There are other types of healthcare practitioners with lots of their own training and experience to serve the people of Maine, but they are not required to do Maintenance of Certification. So this bill wouldn't affect them.

Maintenace of Certification (MOC) is a process by which physicians extend *board certification* in a particular field, which usually coincides with the field in which they trained during their 3-5 year residency program.

As drafted, LD 224 would prohibit an insurance carrier from conditioning network inclusion or reimbursement on MOC.

This committee essentially is asked to determine if MOC is worth it. Is there proven benefit? I dug into the medical literature on this question, and did find some research associating disciplinary actions with lack of MOC. That proves that MOC ensures quality, right?

Or does it? One of the most prestigious of all medical journals, the New England Journal of Medicine published a paper which highlighted the fact that the largest meta-study, or composite study of this issue examined nearly three dozen research papers. Most of them failed to find benefit of MOC, and some even found that MOC was associated with worse quality. Furthermore, studies that fail to show what the authors are looking for, tend not to be submitted for publication. So-called "publication bias" likely means that the denominator of total studies is higher, and the balance of evidence likely is further against requiring MOC.

And the minority of studies that do associate MOC with "quality" are retrospective, observational studies. It would be a classic error of logic to equate association and causation. After all, just because firefighters tend to be found where there is a house fire, doesn't mean that having firefighters on site causes house fires. The firefighters are the *marker* of a problem (the fire), rather than the problem itself. I know that sounds like a frivolous example, but it's meant to convey a serious point: understanding the difference between association and causation is really important when assessing interventions (e.g. pharmaceutical or medical device in clinical practice, or MOC in the policy world). To prove something actually makes a difference, in medicine, the standard is a randomized, controlled trial. I have yet to find one of these gold-standard study designs proving that MOC actually improves quality.

Would we want the FDA to approve a pharmaceutical or medical device for market that has not been proven to work? As with any medication or other intervention, MOC should be proven to work, not assumed to work.

The evidence of its benefit is so lack-luster at this point, that two insurance providers independently contacted me to say they don't even use it as a discriminator for reimbursement or network certification.

As I have continued to examine the issue, I can see reasonable arguments on both sides. We are in a moment of relative uncertainty. But not complete uncertainty.

For the foreseeable future, the decisive consideration for me is the *context* of this decision about MOC. We have in Maine a very fragile, understaffed clinical workforce. This is especially true in psychiatry and other mental/behavioral health profession, which can easily be practiced with telehealth across state lines. That makes it harder for Mainers to get the care they need, and that has direct or indirect negative impacts on all of us. The state of Maine cannot afford to drive psychiatrists away. As is, there is a demographic bubble of physicians, who are within 5 to 10 years of retirement. We can ill afford for them to have an additional reason to throw in the towel.

And I'll remind the committee that this particular reinforcement of the struggling system, so that it can be there for Mainers, wouldn't cost any money.

It is quite possible that in another 5 to 10 years, we will have more evidence with which to more confidently weigh the pros and cons of MOC. As such, I ask the committee to consider a sunset provision of perhaps 10 years.

I thank you very much for your attention, and would be happy to answer questions, though there are people after me whose testimony might answer them.