

# The economics of surgical gynecology: How we can not only survive, but thrive, in the 21st Century

🔍 Q&A with Barbara S. Levy, MD, vice president of health policy at the American College of Obstetricians and Gynecologists

Janelle Yates, Senior Editor

**B**arbara S. Levy, MD, spent 29 years in private practice before accepting an appointment as vice president of health policy at the American College of Obstetricians and Gynecologists (ACOG). Those 29 years in private practice weren't her only window onto the health-care arena, however. She has served as chair of the Resource Based Relative Value Scale Update Committee for the American Medical Association for 3 years; as medical director of Women's and Children's Services at Franciscan Health System in Tacoma, Washington; and as a long-time member of the OBG MANAGEMENT Board of Editors. As a result, she offers an informed and well-rounded perspective on the economics of surgical gynecology—the subject of a keynote address she delivered at the 2012 Pelvic Anatomy and Gynecologic Surgery (PAGS) symposium in December.

We sat down with Dr. Levy after her talk to explore some of the issues she raised—the focus of this Q&A. Dr. Levy also summarizes the high points of her talk in a video presentation available at [obgmanagement.com](http://obgmanagement.com).

**OBG MANAGEMENT:** What prompted you to leave private practice, move across country, and accept the post at ACOG?

**Dr. Levy:** I had spent the better part of

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29 years complaining and feeling reasonably unhappy with what organized medicine was doing—or not doing—for ObGyns and our patients. I felt that the specialty was not really out there in front of the curve, driving the bus, so to speak, but was a victim of broader forces. So when I was given an opportunity to influence the way we approach health-care policy, to enable us to drive our own bus, I decided to take the challenge. I'm not sure I can make a difference, but I'm going to do everything possible to put us in control of our destiny. There are a lot of pitfalls out there, but I think that, given a commitment to doing what is right, we may be able to change the way we deliver health care in this country.

**OBG MANAGEMENT:** So what's wrong with the way we deliver health care in the United States?


**Dr. Levy:** We are spending an inordinate amount of money. I've heard it referred to as an "investment," but I'm not sure that word is accurate. It's really an expenditure of trillions of dollars—as much as 17% of gross domestic product—but what are we getting in return? We're not getting what we want or need. There is a lot of innovation out there, but what is it bringing us? Do we have better health care in this country, based on our per capita expenditure, than other developed nations have? The answer is "No."


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**OBG MANAGEMENT: Why do you think that is?**

**Dr. Levy:** If you look at the growth in Part B Medicare, and focus on where we're spending the money, the culprits are pharmaceuticals, a huge increase in testing and imaging, and a sharp rise in office-based procedures. The complexity of services has also increased dramatically. Our population is aging, and obesity is epidemic and driving costs for management of diabetes, hypertension, and chronic heart disease, as well as joint replacements and back surgery. About 85% of Medicare dollars go to the care of 15% to 20% of the Medicare population. Yes, we're reducing death rates from cardiovascular disease and cancer, but now we have a larger population of patients who have chronic, active disease.

**OBG MANAGEMENT: Who's responsible for this problem?**

**Dr. Levy:** Our health-care systems have created this mess in many ways. We spend \$98 billion annually on hospitalization for pregnancy and childbirth, but our mortality rate is increasing. We rank 50th in the world in maternal mortality despite a cesarean delivery rate over 30%, despite all the money that we're spending—with maternal mortality

higher here than in almost every European country, as well as several nations in Asia and the Middle East.<sup>1</sup>

**OBG MANAGEMENT: Why are we spending so much money?**

**Dr. Levy:** We have become so fearful—of poor outcomes, of litigation, and our patients are coming to us with demands for tests and treatment that cost them little or nothing—that we intervene with tests and procedures that increase the cost of care without providing any true benefit in terms of outcome.

We've also made some poor choices. We've allowed ourselves to be the victims of legislation, of rule-making, because we don't sit down and read the 1,300 or so pages in the Federal Register from the Centers for Medicare and Medicaid Services (CMS) on proposed rule-making every year. Things happen to us that we aren't aware of. We have allowed ourselves to be drawn in by innovation, by testing, and by fear until we have begun to do things that may not have any real benefit for our patients.

Both physicians and hospitals have driven volume to increase reimbursement. And industry has been drawn into the mix

**FAST TRACK**

Although we spend \$98 billion annually on hospitalization for pregnancy and childbirth, our maternal mortality rate is higher than in almost every European country, as well as several nations in Asia and the Middle East

because the medical field is the only one that's expanding. We have become our own worst enemies. We have not stepped up to the plate to define quality and value, so now others are doing it—and they don't necessarily use the same definitions we do. We have allowed our fears of liability and misperceptions about the value of procedures to drive our decisions. For example, when we perform robotic hysterectomy in a woman who is a great candidate for the vaginal approach, we quadruple the cost of the surgery. Consider that we perform roughly 500,000 hysterectomies every year, and you can see how costs mount rapidly.

### Flaws in the US health-care system

**OBG MANAGEMENT:** What are some of the other problems afflicting the US health-care system?

**Dr. Levy:** There are tremendous disparities in quality and cost across the country. Why? How we spend money in health care is cultural. It's influenced by what we become accustomed to, what our particular environment calls "standard." Here's an example: A man who is experiencing knee pain tries to make an appointment with an orthopedic surgeon, but when he telephones the physician's office, he is told that he can't make an appointment until he has an MRI. That's cultural, not medically justified.

Patients also play a role. When the patient comes in with a ream of paper from the Internet, and she wants a CA 125 test because she thinks it's somehow going to *prevent* ovarian cancer, we need to explain to her, in a way she can understand, that adding that testing is of no benefit and may actually cause harm. We need quick statements that can help defuse the demand for increased testing.

### Role of the government

**OBG MANAGEMENT:** What role does the government play?

**Dr. Levy:** The Medicare Resource-Based Relative Value Scale (RBRVS) was enacted

into law in 1992. Most payers now follow this scale to determine reimbursement, based on how many resources it requires to perform a service. Resources are defined in the law—we can't change them. But the American Medical Association did convene the RBRVS Update Committee (RUC), of which I am the chair, to do the best we can to define for the federal government exactly how many of those resources are necessary for a particular intervention. For example, how much time does it really take to perform laparoscopic supracervical hysterectomy—and how does that compare with reading a computed tomography (CT) scan of the abdomen and pelvis or with performing a five-vessel bypass? How many office visits for hypertension does it take to equal an open-heart surgery and 90 days of care? That's not an easy set of relative intensities to work through, but the RUC does do that and makes recommendations to CMS for the relative value units (RVUs) for the services we provide.

**OBG MANAGEMENT:** Is it time alone that determines the value of a service?

**Dr. Levy:** Physician work is defined as the time it takes to perform a procedure—but also as the *intensity* of that service as compared with other physician services.

There are also practice-expense RVUs, intended to address the cost of clinical staff, medical supplies, and equipment. Right now approximately 52% of reimbursement goes toward the practice-expense component, and less than 50% for the physician's work.

In 1992, when the RBRVS was enacted, women's health services were significantly undervalued because ObGyns did not form a large part of the Medicare fee schedule. Over the past 20 years, ACOG and the RUC have worked diligently to correct those initial inequities.

On the RUC, we believe that no physicians are paid at a level that is fair and appropriate, compared with a plumber or electrician. So the shift to a value-based system and away from the volume-based system may be beneficial to us.



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## Challenges ahead

**OBG MANAGEMENT:** What challenges do ObGyns face in attempting to overcome these problems?

**Dr. Levy:** The primary challenge is to face reality as it is—not as it was in the “good old days” or as we wish it to be. We need to become advocates for ourselves and our patients. Advocacy would support and promote our patients’ health-care rights and enhance community health. It would also foster policy initiatives that focus on availability, safety, and quality of care.

In our advocacy, we need to focus first on quality. If we don’t define quality ourselves, others are going to decide that quality is a constant and that the only thing that matters is cost, and they will shift all services to the lowest-cost providers. That is not the way we want things to go.

Some changes are already in play:

- Out-of-pocket costs for patients are increasing, motivating patients to become more discriminating
- Payment models will soon focus on “episodes of care,” with incentives for systems to reduce surgical volumes while preserving the patient’s quality of life
- Surgery will shift from low-volume surgeons to high-volume physicians who have demonstrated excellent outcomes. This is otherwise known as “value-based purchasing,” based on a model from Harvard Business School.<sup>2</sup>

## Bundled payments will become the norm

**OBG MANAGEMENT:** Can you elaborate a bit on episodes of care?

**Dr. Levy:** By episode of care, I mean bundled payments. For example, pregnancy services where prenatal care, delivery, and postpartum care are bundled, or management of fibroids where the diagnosis, imaging, medical, and, potentially, surgical management could all be included in a single payment. All interventions in these periods would be grouped together and reimbursed at a set rate. As a result, the clinicians caring for the

patient during these episodes have more of an incentive to reduce unnecessary costs. Are a first-trimester ultrasound scan and two second-trimester scans really necessary? Or might there be a less expensive way to ensure the same optimal outcome? Are the fibroids symptomatic or might observation be a more appropriate option for the patient?

**OBG MANAGEMENT:** Some people might assume you are prescribing “cookbook medicine” by urging a reduction in variations in care.

**Dr. Levy:** Not at all. I’m talking about reducing significant variations in outcomes, not processes. Physicians should remain free to treat the patient, using whatever approach they deem to be in her best interest. However, cost pressures mean that we will need to become more creative in keeping costs down without impairing outcomes.

**OBG MANAGEMENT:** What will happen if physicians don’t keep these cost pressures in mind?

**Dr. Levy:** People are already keeping score. CMS and payers are using ICD-9 diagnoses, married to the CPT code—the intervention, as well as the episode—and including the costs of things we may have no idea are being spent, such as pharmaceuticals, a return to the emergency room, and so on. We need to be aware of what other people are measuring. We need to understand what we are being measured on: patient satisfaction, quality of life, morbidity and mortality, and cost.

## What can gynecologic surgeons do?

**OBG MANAGEMENT:** Here’s the million dollar question: What can gynecologic surgeons do about this problem?

**Dr. Levy:** We need to step up to the plate. We need to read the literature *critically* to focus on clinically meaningful outcomes. Although small differences in blood loss, analgesic use, or operating times may be statistically significant, they do not produce outcomes that are apparent and meaningful to our patients.



**Payment models will soon focus on “episodes of care,” with incentives for systems to reduce surgical volumes while preserving the patient’s quality of life**

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We also need to encourage comparative effectiveness research, which is essential to ensure the most clinically meaningful and cost-effective care.

Now that “DSH” payments—disproportional share, or the incremental amount of money that hospitals collected to reimburse them for care of the uninsured—are going away, hospitals are going to need to cut expenses 20% to 25% over the next 3 years to survive. You can bet they are going to change the way they look at you. Be prepared for them to limit the “toys” you are allowed to have, and other cuts.

**OBG MANAGEMENT:** Can you recommend specific steps?

**Dr. Levy:** Yes, we need to:

- **think creatively to contain costs.** A good book on this subject is *Unaccountable: What Hospitals Won't Tell You and How Transparency Can Revolutionize Health Care*, by Marty Makary, MD.<sup>3</sup>
- **track our own outcomes.** Although it is irritating and time-consuming to enter data, it's a little easier with electronic medical records. We need to document our own long-term outcomes. In fact, ACOG is working with the American Board of Obstetrics and Gynecology to look at ways we can create a structure for us to track our own outcomes as part of the maintenance of certification (MOC) process. When you track data, the Hawthorne effect comes into play: You get better at the activity you're tracking, simply by writing it down.
- **collaborate with others** in our communities to improve public health issues such as obesity, smoking, and teenage access to contraception

- **question and challenge preconceived notions and beliefs.** We have a lot of them in surgery. For example, we tell patients not to lift after hysterectomy, not to have sex after hysteroscopic resection—but we have absolutely no data suggesting that these admonitions are helpful. Bowel prep is another example. Data have demonstrated that it not only does not benefit the patient, mechanical prep causes harm—but the randomized, controlled trials documenting this fact appear in the surgical literature, not the gynecologic literature. And guess how long it takes for us to incorporate definitive data like that into gynecologic practice? 17 years.

- **get a seat at every table** to participate in data definitions, acquisition, and dissemination to inform our daily clinical decisions
- **participate in efforts to define and improve quality of care.**

**OBG MANAGEMENT:** Any last comments?

**Dr. Levy:** I just want to emphasize how important it is that we take control of our destiny. If we are not at the table, we may be on the menu! But if we step up to the plate and approach these challenges the right way, we can become the premier surgical specialty. 🍷

**References**

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**FAST TRACK**

ACOG is working with the American Board of Obstetrics and Gynecology to find a way we can create a structure for us to track our own outcomes as part of the MOC process



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