Ob.Gyn. News

www.obgynnews.com

VOL. 47, NO. 5 *The Leading Independent Newspaper for the Obstetrician/Gynecologist—Since 1966* MAY 2012

WHAT'S NEWS

ACA's Uncertainties Loom Large for Practices

If the law is completely reversed, 'there's going to be huge chaos.'

BY ALICIA AULT

The fate of the Affordable Care Act won't be known until at least June – and that adds a significant element of uncertainty for physicians trying to manage their practices.

The Supreme Court is expected to issue an opinion on the law's – and its components' – constitutionality some time before its current term ends in late June. Given the complexity of the issues heard during oral arguments in late March, most observers do not expect an opinion any earlier.

The tenor of the four conservative-leaning justices' questioning during arguments suggested that all, or at least some, of the law might be struck down. Justice Clarence Thomas, who generally is silent during arguments, is seen as being in the conservative camp, as well.

Some court-watchers cautioned against reading too much into the arguments. "Questions asked by justices don't necessarily predict what they're going to do and how they're going to vote," said Neal K. Katyal, a professor at Georgetown University School of Law, Washington, and a former acting solicitor general, in an interview.

The court will decide on four questions:

- Is it within Congress's authority under the Commerce Clause to require Americans to buy insurance?
- Can Congress levy a penalty if they don't?
- Can the remainder of the law outside the mandate be upheld separately?
- Is the federal requirement that Medicaid be made available to Americans up to 133% of the federal poverty line an acceptable use of federal powers?

Most physician organizations said that they would be happy to see at least one part of the law struck down: Medicare's Independent Payment Advisory Board. But the notion that any or all of the remainder of the law could be overturned is causing some to be uneasy. Some physicians might not even be aware of the potential ramifications of a partial or full rollback, said Bob Doherty, senior vice president of governmental affairs and public policy at the American College of Physicians. "If they throw the whole thing out, to me it's like throwing a hand grenade into a

See **Uncertain Future** *page 3*

AAGL Creates COEMIG to Improve Outcomes

BY SHARON WORCESTER

A minimally invasive approach is increasingly accepted as the standard of care when it comes to gynecologic surgery, and insurance payers, who were slow to accept this approach, now recognize its value for improving outcomes and lowering costs, according to Dr. Steven F. Palter.

Enter COEMIG – the Center of Excellence in Minimally Invasive Gynecology Program.

"COEMIG is a revolution in minimally invasive gynecology. Instead of focusing on a single operation or doctor, it ensures an entire system is in place to deliver the highest quality of care," said Dr. Palter, medical and scientific director at Gold Coast IVF in Syosset, N.Y.

COEMIG was officially launched in November 2011 by the AAGL to establish a comprehensive network of surgeons, hospitals, and ambulatory

See **COEMIG** *page 6*

COURTESY GERALD PALTER

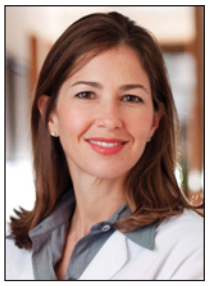
Dr. Steven F. Palter said, "We know the minimally invasive approach results in a quicker recovery, lower morbidity, and lower costs."

Centers of Excellence

COEMIG *from page 1*

care centers that have demonstrated excellence in advanced minimally invasive techniques. The program, administered by the nonprofit Surgical Review Corporation (SRC), also provides a central outcomes database known as the Bariatric Outcomes Longitudinal Database (BOLD), which is designed to advance the delivery of evidence-based medicine.

The database is accessible by all COEMIG surgeons for use in clinical decision-making.



For years, the AAGL has worked to promote its vision of "serving women by advancing the safest and most efficacious diagnostic and therapeutic techniques that afford less invasive treatments for gynecologic conditions through integration of clinical practice, research, innovation, and dialogue," but acceptance was limited, and patients were too often unaware that minimally invasive approaches even existed, said Dr. Palter, who founded and directs the COEMIG program and chairs the program's outcomes committee.

"We know the minimally invasive approach results in a quicker recovery, lower morbidity, and lower costs. Now that insurance companies are also recognizing this, we are in a position to create a network of Centers of Excellence based on the highest quality of care," he said in an interview.

Questions have been raised about if and how the Center of Excellence model will change the landscape for minimally invasive gynecologic surgeons, and the answers, Dr. Palter said, are yes – and in potentially very beneficial ways.

The scenario has played out in several other specialties, which have had great success with Centers of Excellence programs, he said.

In fact, the field joins more than half a dozen other specialties in pursuing this model as a means of raising the level of care in the specialty and verifying those centers that perform at the highest level.

Those in the program generate and own the evidence and data needed to answer the most pressing clinical questions in the debate about the value and benefits of minimally invasive procedures. As a result, care will improve, patients will benefit, and participating surgeons will have improved access to patients and improved levels of reimbursement, he added.

Ultimately, COEMIG is about bringing patients and surgeons together, and improving outcomes, he said, providing the field of bariatric surgery as a classic example of this.

Bariatric surgery moved to this model beginning in 2003, as procedures for obesity increased and a need for the development of benchmarks for quality and patient safety was recognized.

In fact, SRC was founded by the American Society for Metabolic and Bariatric Surgery for this purpose, and currently more than 1,100 bariatric surgeons and 600 centers worldwide are designated as, or approved for provisional status as, Centers of Excellence in Bariatric Surgery worldwide through programs administered by SRC.

Additionally, the BOLD database for bariatric and metabolic surgery, launched in 2007, is the world's largest and most comprehensive repository of related clinical bariatric surgery patient information. Data are included from more than 500,000 patients, allowing surgeons to obtain meaningful data through daily reports based on individual practice and national data summaries.

BOLD data also provide an "unmatched infrastructure for clinical studies," according to information from SRC, which works with investigators to design such studies in addition to administering and supporting the Center of Excellence programs.

The experience of bariatric surgeons has been that participation in a Center of Excellence program leads to greater patient access and the highest levels of reimbursement, SRC reports.

COEMIG will do the same for minimally invasive gynecologic surgery, Dr. Palter predicted.

"COEMIG is meant to be inclusionary, not exclusionary," he said, noting that the designation of Center of Excellence is open to any surgeon, hospital, or ambulatory surgery center performing minimally invasive surgery. Certainly there are quality standards and infrastructure requirements, and there is particular emphasis on the entire team, but the AAGL and SRC will work with those who don't currently meet the guidelines to improve.

Insurance companies 'may eventually demand that surgeons be part of a Center of Excellence.'

DR. ORBUCH

Participation is meant to allow those surgeons to have continued access to patients who might otherwise be steered away by insurance companies that will mandate care through approved centers in a network. For the first time, centers around the world will be able to share and learn from each other's best clinical pathways and raise their performance to the highest possible level, he said.

Rather than serving as a "rubber stamp" program, COEMIG promotes an ongoing, interactive process for achieving and maintaining excellence, he added.

To date, more than 150 programs have registered for the designation and are in various stages of application completion. The process involves:

► **Registration and account creation.** This is done at the SRC website (www.surgicalreview.org) or through the AAGL website (www.aagl.org).

► **Achieving provisional status.** This is done by linking accounts of related registrants (surgeons, facilities, and so on) that together comprise the "center," by submitting an application that indicates provisional qualifications are met or exceeded, and paying the fees associated with the application process (currently $7,500 for a facility; $650 for individual surgeons).

► **Earning COEMIG designation.** This means a site visit by SRC administrators (materials are sent upon receipt of the application to assist with preparation for the site inspection; the site inspection fee is $1,850) and by meeting all qualifications. There are particular qualifications for the individual surgeons and facilities. (See box.)

Once all applicants for a given center are approved, the surgeons and facilities may publicly announce and market their designation. The annual participation fee is $3,975 for a facility and $650 for individual surgeons.

Designation maintenance requires good standing and verifiable compliance with requirements. Verification is completed approximately every 3 years as part of a designation renewal process; support is provided by SRC as needed.

Dr. Iris Orbuch, a New York–based surgeon who specializes in robotic and minimally invasive surgery for benign gynecologic conditions – particularly endometriosis – is currently in the process of certification for the COEMIG designation.

After hearing a talk about the future of the specialty a couple of years ago – and about the benefits achieved through Center of Excellence programs in other specialties – Dr. Orbuch was intrigued by the concept.

The potential for improved patient outcomes through outcomes data collection was a major selling point, and it didn't take much convincing before New York's Beth Israel Medical Center, one of the facilities with which she is affiliated, was on board as well, she said in an interview.

After several months of meetings and preparation, including the creation of planning committees, collection of data, and training of staff, Beth Israel Medical Center has applied for the COEMIG designation.

Dr. Orbuch, director of the Advanced Gynecologic Laparoscopy Center in New York, said she sees the process – and the designation – as a way not only to promote the value of minimally invasive gynecologic surgery and to plan for an uncertain future in the best way possible, but, most importantly, to improve outcomes for patients by ensuring that they are in the hands of those with the most experience and the greatest skill. In fact, the actual process of applying for COEMIG led to the creation of systems, protocols, and processes that have already greatly improved the quality of care provided, she said.

"The direction of medicine is changing, insurance companies are changing, and they may eventually demand that surgeons be part of a Center of Excellence," she said.

Indeed, it's a pattern that has played out in bariatrics, and there is no reason to think the same won't be true for gynecology, Dr. Palter agreed.

Neither Dr. Palter nor Dr. Orbuch had conflicts of interest to disclose. ■

COEMIG Requirements For Individual Surgeons And for Facilities

Requirements for surgeons:

1. Experience. This includes at least 50 qualifying laparoscopic procedures and/or 25 qualifying hysteroscopic cases performed in the preceding 23 months.

2. A physician program director. This is a minimally invasive gynecologic surgeon at the surgeon's facility who is also designated, or in the process of becoming designated, as a COEMIG surgeon.

3. Surgeon experience and qualified call coverage. This means the surgeon must be board certified and spend a significant portion of their efforts on minimally invasive gynecologic surgery, and must have qualified coverage for postoperative patient care.

4. Informed patient decision-making and consent. This includes established procedures for providing patient education and obtaining informed consent.

5. Continuous quality assessment. This includes a willingness to share surgical outcomes data.

Requirements for facilities:

1. Commitment to excellence.

2. Surgical experience and volumes. This means a minimum of 75 qualifying procedures in the preceding 12 months.

3. A designated physician program director.

4. Consultative staff. This means a full complement of consultative services is required for the care of minimally invasive gynecologic surgery patients.

5. Board-certified surgeons and qualified call coverage.

6. Appropriate equipment and instruments. This includes a full line of surgical instruments and related equipment for providing appropriate perioperative care, and also documented training for staff in the safe operation of the equipment.

7. Clinical pathways and standard operating procedures. Eight specific pathways are recommended by SRC.

8. A designated surgical team and support staff.

9. Processes for informed patient decision-making and consent, and continuous quality assessment.

Source: Dr. Palter