



☑ IMPROVE THE HEALTH CARE DELIVERY SYSTEM

America's neurosurgeons strongly support improving our nation's health care system, including expanding access to affordable health insurance coverage for every American, as well as reforms to redress a number of inexcusable insurance practices. While the Affordable Care Act's (ACA) insurance market reforms — such as coverage for pre-existing conditions and guaranteed issue — provide critical consumer protections, rather than lowering costs and expanding choice, premiums have skyrocketed, high deductibles leave patients financially on the hook for their medical bills and narrow networks restrict patient access to the physician of their choice. To address these ongoing shortcomings, policymakers must take additional steps to require plans to offer a sufficient number and type of specialists and subspecialists in their provider networks; maintain patient choice through out-of-network options; improve access to trauma and emergency care; reduce preauthorization requirements; and expand competition and the choice of health plans — including health savings accounts. Additionally, to ensure that our nation's children health insurance coverage, Congress should reauthorize the Children's Health Insurance Program (CHIP) — for two to five years.

☑ SUPPORT QUALITY RESIDENT TRAINING & EDUCATION

An appropriate supply of well-educated and trained physicians — both in specialty and primary care — is essential to ensure access to quality health care services for all Americans. Unfortunately, the nation is facing an acute shortage of physicians, due to an aging population and the expansion of health insurance coverage through the ACA. And while medical schools in the U.S. have increased their enrollments, and additional medical and osteopathic schools have been established, the number of Medicare-funded resident positions has been capped by law at 1996 levels. To ensure an adequate supply of physicians and allow the graduate medical education system to operate optimally, policymakers should:

- (1) eliminate the current graduate medical education (GME) funding caps and increase the number of funded residency positions;
- (2) expand funding to fully cover the entire length of training required for initial board certification;
- (3) channel a larger percentage of GME funds directly to the academic departments responsible for resident education;
- (4) maintain current financial support for children's hospital GME;
- (5) encourage all payers to contribute to GME programs;
- (6) allow residents to bill for the services they render after achieving verified competence in particular skills;
- (7) provide additional funding to investigate innovative approaches to modernized GME;
- (8) supply the profession with the tools, including antitrust relief, to ensure a well-trained physician workforce;
- (9) preserve the ability of surgeons to maximize education and training opportunities by performing overlapping surgical procedures and allowing for flexible resident duty hours; and
- (10) reject additional unnecessary layers of regulations and ensure that the Accreditation Council for Graduate Medical Education (ACGME), American Board of Medical Specialties (ABMS) and Association of American Medical Colleges (AAMC) retain their preeminent roles in overseeing resident training and education.

☑ ABOLISH THE INDEPENDENT PAYMENT ADVISORY BOARD (IPAB)

Established by the ACA, the IPAB is a 15-member government board — whose members are appointed by the president — with little or no clinical expertise or the oversight required to protect access to care for our country's seniors, has only one job: to cut billions of dollars from Medicare. Even worse, if no board is appointed, which is the situation right now, the Secretary of Health and Human Services has the sole authority to make these decisions. Proposed spending cuts automatically go into effect if Congress does not replace the recommendations with cuts of equal magnitude. Congress only has a very short time in which to pass its substitute proposal — making it a virtual certainty that the board's recommendations would be adopted. The AANS and CNS strongly urge repeal of the IPAB because leaving Medicare payment decisions in the hands of an unelected, unaccountable governmental body with minimal congressional oversight will negatively affect timely access to quality neurosurgical care for our nation's senior citizens and those with disabilities.

☑ ALLEVIATE THE MEDICAL LIABILITY CRISIS

The AANS and CNS support legislation to provide common sense, proven, comprehensive medical liability reform. Federal legislation modeled after the laws in California or Texas, which includes reasonable limits on non-economic damages, represents the "gold standard." The Congressional Budget Office has determined that comprehensive medical liability reform would save the federal government approximately \$65 billion over 10 years. Other solutions should be adopted including: (1) applying the Federal Tort Claims Act to services mandated by the Emergency Medical Treatment and Labor Act (EMTALA); (2) liability protections for physicians who volunteer their services; and (3) liability protections for practitioners who follow practice guidelines established by their specialties.

☑ CONTINUE PROGRESS WITH MEDICAL INNOVATIONS

America has a long tradition of excellence and innovation in patient care, and neurosurgeons have been on the cutting edge of these advancements. However, American medical innovation is at serious risk. While temporarily suspended for two years from 2016-17, the ACA's medical device excise tax is adversely affecting medical innovation and patient care. The AANS and CNS support repealing this tax. Additionally, while passage of the 21st Century Cures Act made critical improvements in the Food and Drug Administration's (FDA) drug and device approval processes, officials should carefully monitor implementation to ensure progress and patient access to pioneering medical technology and lifesaving therapies. Furthermore, modifications should be made to the Sunshine Act to encourage appropriate interactions between physicians and industry and reduce reporting burdens. Finally, Medicare payment and coverage policies can stifle innovation if they are overly limiting. Accountable care organizations, bundling and not paying for procedures in which new technology is used may seem cost effective in the short run, but if they prohibit the development of safer and better procedures that get patients back to health, work and activity faster, they may be much more costly in the long run. Thus, the AANS and CNS urge policymakers to prevent inappropriate reimbursement policies that may delay or deny appropriate care for patients.

☑ RESTRUCTURE MEDICARE QUALITY IMPROVEMENT PROGRAMS

The AANS and CNS are fully behind efforts to improve the quality of care that neurosurgeons deliver to our patients. And while Congress has taken the first steps towards implementing improved quality improvement programs with the passage of the Medicare Access and CHIP Reauthorization Act (MACRA), as implemented by the Centers for Medicare & Medicaid Services (CMS), the Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) programs fail to appropriately capture the objectives of this physician payment reform law. Despite the new law, MIPS continues the current "siloed" approach to quality reporting. This will not result in better patient outcomes; rather it perpetuates the flawed "check-box" system of reporting that does little to improve quality and increase value in the Medicare program. As the implementation of MACRA continues, organized neurosurgery recommends that policymakers minimize the complexity and reduce the regulatory burden of the MIPS and APM programs. Moreover, it is essential that the determination of quality remains in the hands of the profession, and specialty-specific quality measures, clinical data registries and alternative payment models developed by clinicians, not the government, must be advanced. This will ensure flexibility for physicians to adopt objectives and measures that enhance and meet the needs of their patients and practice. Additionally, electronic health record (EHR) systems remain very costly to implement and maintain—often with little or no demonstrated benefit to patients — and the promise of EHR use remains elusive. It is essential that serious strides are made to achieve interoperability and EHR vendors must be prevented from data blocking, particularly between EHRs and clinical data registries. Finally, the AANS and CNS urge Congress to adopt legislation to pause and revisit the necessity and value of the Medicare AUC Program for advanced diagnostic imaging.

☑ CHAMPION FAIR REIMBURSEMENT

Our nation's seniors deserve the freedom to select the physician of their choice, but in certain circumstances, Medicare limits this option. To empower patients and preserve timely access to care, policymakers should allow patients and physicians to privately contract — without penalty to either patient or physician — and maintain a viable fee-for-service option in Medicare. Preserving this option for Medicare beneficiaries is especially critical for those patients seeking specialty care. Additionally, to ensure access to vital surgical services, Medicare must maintain the 10- and 90-day global surgery payment package and prevent CMS from using flawed or incomplete data gathered from the global surgery code data collection initiative to revalue global surgery codes.

☑ MODERNIZE THE MEDICARE PROGRAM

To modernize the program, the AANS and CNS believe that we need to move from Medicare's current defined-benefit structure to a defined contribution model. Like the Federal Employee Health Benefit Program (FEHBP), this bipartisan model would pay Medicare beneficiaries a certain sum toward the purchase of an insurance policy that provides a defined set of services. Seniors would then pick from an array of health plan choices, allowing them to choose the plan that works best for them. It is essential that such a system incorporates consumer protections and that the premium subsidies are adequate to provide beneficiaries with appropriate coverage for their medical needs. To this end, the premium subsidy must be risk-adjusted so that the sickest beneficiaries are not unfairly penalized because of their health status and lower-income seniors should receive a higher federal subsidy than wealthier seniors. Finally, it is important that all current Medicare beneficiaries are allowed to remain in the existing Medicare program — if they so choose — and we believe that it makes sense to align the Medicare and Social Security eligibility ages.

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