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September 30, 2009

L.D. Britt, MD, FACS, Chair
Board of Regents
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Dear Dr. Britt,

As Congress gets closer to voting on health system reform legislation, the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS) would like to provide you with additional feedback on those provisions that concern us the most and urge the College to consider our positions on these issues as the surgical coalition moves forward with our lobbying and negotiations with policymakers. **From our standpoint, surgery needs to draw a line in the sand and actively oppose any bill that includes any of these provisions as we believe them to be significantly detrimental to surgeons and our patients.** As we have stated in past correspondence to the College, the AANS and CNS are committed to achieving meaningful healthcare reform legislation, but the current bills under consideration go far beyond what is necessary to fix what is broken with our healthcare system and they grant the federal government considerable new powers and authority, which could ultimately amount to a complete government takeover of healthcare – a result that is anathema to doctors and patients alike.

The Public Health Insurance Option

There is no question that the inclusion of the public health insurance option will lead to more and more people being covered by this government run plan. As some commentators have suggested, the public option is the entire camel under the tent toward a single-payer, government run healthcare system. In addition, under the public option, the government is empowered to set benefits and implement rules that would restrict patients' choice of physician and limit timely access to quality care. Furthermore, the problems with the public option are not solved by merely requiring the government to negotiate reimbursement rates with providers or other mechanisms to ensure that payment is not tied to Medicare rates. The entire concept is problematic and the reimbursement scheme under such an option is not the paramount issue.

The Medicare Commission

The AANS and CNS appreciate the leadership the College has shown in vocally objecting to the establishment of an Independent Medicare Commission. As you know, in July a coalition of 16 surgical societies expressed our grave concerns about this idea in a letter to House Speaker, Nancy Pelosi, where we stated:

> Should provisions to place the authority for Medicare payment policy in an unelected executive agency be included in any legislation at any point, the surgical community ***would vigorously oppose this legislation regardless of any other provisions that may be included***. [emphasis added]

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We are fundamentally opposed to taking Medicare policy decisions out of Congress and replacing the transparency of Congressional hearings and debates with a minimally open process overseen by unelected officials with little accountability for the healthcare decisions it makes. We view this structure as an opportunity for a handful of individuals to implement sweeping changes to the Medicare program, with limited opportunity for Congress to intercede and with no judicial review of any decisions made by the Commission. To place a healthcare program of this magnitude (projected expenditures for Medicare exceed $500 billion in 2010) in the hands of so few individuals is, to us and others, unacceptable. We also note that the current interpretation of the Baucus bill exempts hospitals from this policy. This is outrageous, fundamentally unfair, and points to why the entire provision must be struck from the bill.

CMS Payment Innovation Center

Like the College and other surgical societies, the AANS and CNS are very concerned about the proposed CMS Payment Innovation Center as it is currently constructed. Indeed, as we interpret these provisions, the Innovation Center would have more authority and power than the Independent Medicare Commission in that the Secretary of HHS would have the authority to enact national-level reforms in either Medicare or Medicaid that improve care, reduce costs, or both, ***without requiring consideration by Congress or the President***. These changes would be done under the guise of "pilot" studies, rather than "demonstration" projects. This, as you may know, is a distinction with a significant difference. A demonstration project is essentially a research study. It has an end date and providers are recruited to participate for a certain period of time. If it proves beneficial, then the research findings could serve as the basis of legislation to broaden the demonstration program further or change Medicare policy. A pilot, on the other hand, is simply an initial step to implement a policy. It may be watched closely, and if government officials deem it to be working or meeting the policy goals of the pilot, it can be expanded. In essence, under this authority, CMS could use its authority to make extensive changes to Medicare and Medicaid without Congressional involvement simply by calling the new policy a "pilot" study.

The AANS and CNS are not opposed to exploring new healthcare delivery and payment models. Indeed, we have repeatedly called on Congress to include in health system reform legislation a variety of demonstration projects to evaluate such ideas as Accountable Care Organizations and bundled payments. However, we believe that these concepts should be tested under the demonstration model, rather than under pilot study rules to ensure adequate input from the medical community, beneficiaries and Congress. We therefore urge the College to request that this broad pilot authority be rescinded and changed to targeted demonstration project authority instead.

Physician Payment Policy

There are a number of physician payment policies (in Senator Baucus' draft legislation in particular) that we oppose. Individually, each of these is enough to give us serious pause, but when taken together, we do not see how the College can possibly support legislation that includes these provisions. The following provisions are particularly troubling:

- The temporary one-year SGR "patch" to replace the 21.5 percent payment cut in 2010 with a 0.5 percent payment increase in the Baucus bill does little to address the serious underlying problems with the current Medicare physician payment system and compounds the accumulated SGR debt, causing a payment cut of approximately 25-28 percent in 2011.
- In the Baucus bill, one-half of the 10 percent bonus payment to primary care physicians and general surgeons would be paid for on the backs of all other physicians through an across-the-board, budget neutral, cut in reimbursement.
- The bills inappropriately expand the government's involvement in determining the quality of medical care and resource use. Under the Baucus plan, doctors are mandated to participate in the Physician Quality Reporting Initiative (PQRI) -- which does not effectively measure quality – or their fees will be cut by 2 percent and physicians who fail to comply with national resource use benchmarks face cuts of 5 percent.

- The new payment modifier included in the Baucus bill that is aimed at paying physicians or groups of physicians differentially based on the relative quality of care they achieve for Medicare beneficiaries relative to cost is completely untested. Furthermore, it is sheer folly to believe that the government can develop a composite of appropriate measures of quality that reflect the health outcomes of Medicare beneficiaries, when the tools to measure health outcomes are not even in place. Neurosurgery is moving forward with a new registry to collect clinical data, and we are collaborating with the Surgical Quality Alliance to investigate the feasibility of a surgical quality data base, but these systems are not fully operational and, in our field, no other system to assess neurosurgical quality currently exists. We suspect this is the case for most specialties and so this idea is clearly not ready for "prime-time."
- The bills create a duplicative process for determining code values. The surgical coalition supports maintaining the role of the AMA/Specialty Society Relative Value Update Committee (RUC) as the entity through which medical services are valued. The RUC – although not perfect – continues to be a dynamic process, which makes recommended increases and decreases in the value of codes reimbursed under the Medicare Physician Fee Schedule. A new "shadow RUC," consisting of so-called health policy experts (which will not likely be dominated by practicing physicians) will likely remove the ability of the profession to effectively oversee this important function. An additional affront to practicing physicians is the House proposal to remove the authorization for the Practicing Physician Advisory Council. While the PPAC may not have much authority or influence over Medicare physician payment policies, it is at least one ongoing opportunity for practicing physicians to voice their concerns and opinions about Medicare to government officials and other interested parties.

Other Issues

The above issues are not our only concerns with the current healthcare reform legislation. Patient-centered healthcare is threatened by provisions curtailing the development of physician owned specialty hospitals and changes to office-based imaging. The bills fail to recognize the looming workforce shortages in surgery by requiring that all unused medical residency training slots be allocated to primary care and placing the emphasis on national workforce policy on primary care, to the exclusion of surgical (other than general surgery) and other specialty care. The House bill inappropriately expands the government's involvement in determining the quality of residency training programs. And the House provisions related to comparative effectiveness research could potentially stifle medical innovation and restrict patient access to valuable, life-saving, treatment options.

The AANS and CNS also cannot ignore several key issues which are vital to any overhaul plan and are missing from this bill including: concrete options for proven medical liability reform and protections to ensure patient choice of physician, including the right of patients to privately contract with their physicians.

A Note about the SGR

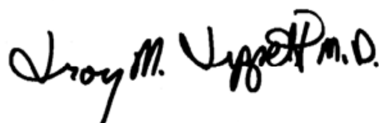
The AANS and CNS clearly support repealing the current sustainable growth rate formula and establishing a new budget baseline for the physician payment system. Like the College, we certainly do not want physician reimbursement to be cut by nearly 22 percent next year (and by a total of 40 percent over the next several years). However, we do not believe that the SGR is ***the*** issue that trumps all other issues in healthcare reform legislation. It would be a real shame if the College either endorses or merely withholds its support for healthcare reform legislation that includes SGR reforms as provided in the House bill if, at the same time, said legislation also incorporates the provisions that we highlighted above. In our view, the short-term reimbursement benefit is simply not worth the long-term costs associated with more government oversight and involvement in the practice of medicine. Ultimately, this would not be good for patients and it would certainly not be good for the profession. Congress is not going to let these SGR cuts go into effect and so we hope that the College will not be coerced into backing a healthcare reform bill that includes many problematic provisions for the sake of SGR reform.

Grassroots Activism

Finally, the AANS and CNS would like to encourage the College to activate its grassroots and encourage surgeons to contact their Members of Congress on key issues – those things that should be included, as well as those that we oppose being included. While we appreciate that things in Congress are still fluid, and final bills have not yet been crafted, if we wait until the last minute to engage surgeons in the debate, we fear it will be too little, too late. We still have an opportunity to shape the final legislation if we can mobilize our nation's surgeons, and the AANS and CNS look forward to contributing to this grassroots effort.

Thank you for considering our thoughts and recommendations. We look forward to our continued participation in the surgical coalition and stand ready to help pass healthcare reform legislation that is good for surgeons and patients alike.

Sincerely,



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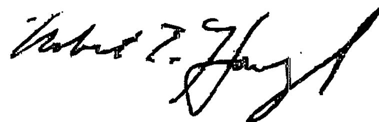

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