Dr. Steinmetz celebrated the group for a great first meeting during his tenure as chair. During his address, he focused on how we contribute to the age of reason – playing on the theme for the current CNS meeting. He noted that medical expertise and evidence are currently being challenged by hearsay and pseudoscience. He gave examples of ways that the CSNS firmly advances “the age of reason” by creating new committees and functions, including for wellness and patient safety. He highlighted the increased resolution throughput which has resulted in meaningful work product including peer reviewed articles, surveys, and white papers, as well as educational content at parent organization meetings. At the current meeting, 12 socioeconomic sessions have benefitted from CSNS support. These sessions incorporate such important topics as social media use in practice, entrepreneurship, and regulatory topics. He highlighted multiple peer reviewed articles present in the literature which originated from the CSNS and currently are influencing neurosurgical practice. He notes that the CSNS partnered with the WC to offer grassroots support for national legislation regarding surprise billing, by mobilizing rank-and-file neurosurgeons to advocate for themselves and their patients. In order to continue to remain relevant for neurosurgeons, Dr. Steinmetz noted the importance of fostering and developing state societies, which he is actively seeking to engage. This has comprised a significant part of the new CSNS Strategic Plan developed under his tenure.
SHORT REPORTS

Financial Feasibility

Financial feasibility was a theme of multiple talks. Dr. Tumialan (treasurer) reviewed the financial state of the organization and thanked the state societies that have paid their dues. He noted that resident fellowship funding would be decreased from $1000 per meeting to $500 per meeting. Dr. Rosenow noted further strategies of financial feasibility such as scaled back food during meetings and scaled back FTE for administrator. A change that generated some discussion was a planned change to relax the requirement that the CSNS have two meetings per year, although there are no current plans to scale back to one meeting per year.

Strategic Planning Summary

A renewed focus on strategic planning tried to provide new focus and clarity to the purpose of the CSNS. A new Mission Statement was created after input with many stakeholders to distill the key foci of the organization: “to be the premier socioeconomic resource in neurosurgery through patient and physician advocacy, education, and leadership training.” The renewed strategic planning initiative also tried to answer the question “how to we track and measure success?” – then created metrics for each individual committee to help document what the organization does and its overall worth.
COMMITTEE REPORTS

Workforce
Karin Swartz MD

Using the Lexinexis and Westlaw databases, a study of the enforceability of the Noncompete Clause in Neurosurgery was undertaken; this was written up, with a manuscript sent to Jeff Cozzens for inclusion in the upcoming SocioEconomic Handbook, and we also anticipate completion of a white paper, with presentation of the results at the 2020S CSNS meeting. We have prepared a survey for the Allied Practice Providers, for which we are awaiting the results, to review current practice patterns (2017S resolution). A retirement survey was also created (generated by a 2017F resolution); we are awaiting the conclusion/vote and discussion from this current meeting regarding a parallel resolution (RES IV-2019F) as we move forward with the analysis and planning.

Patient Safety
James Wright MD

At the 2019 CSNS meeting the Patient Safety Committee (PSC) focused on several issues relevant to patients and practicing neurosurgeons. The initiatives on which we are currently working are topics of gun violence and data acquisition, a survey of patterns of opioid use, development of review boards for spinal neurosurgical cases, and comparative data analysis of reported Patient Safety Scores and HCAHPS data. We are in the process of generating several white papers on topics of workplace violence, cyber security, diagnostic errors, and the peer review process and expect abstracts on these topics to be presented at upcoming parent body meetings. A resolution put forth by a member of the PSC was passed to generate a white paper to examine the feasibility of screening of at risk-patients with TBI for issues relative to firearm safety and gun violence. Future directions of the PSC are to identify issues and areas of improvement relevant to physician wellness/burnout and to work towards the development of a safety & wellness symposium in conjunction with parent body organizations.

Coding and Reimbursement
Cletus Cheyuo MD, PhD

CPT Code Change Applications (CCA) for 63047 and 22633 have been postponed till February 2020. Neurosurgery/NASS updated CCA with 63048 for decompression of 2 nerve roots. The plan is to have the CPT staff send list of concerns raised by the panel. Other coding issues include the deformity fusion code (22802) with combo code (22633). The plan is to ask CPT to rescind, pending completion of an article with NASS. There have also been a number of industry requests for development of CPT codes for a number of procedures. Industry “Monster” has applied for a CPT code for LITT for brain tumors (Category I). This will require a review of the literature for the level of evidence. “Brain box” is another industry request that has passed category III code. Another industry request for code development is for 5-ALA-guided tumor resection.

RUC RAW action plans include requests to remove from new technology screen accepted for CPT codes 61645, 50 and 51 as well as intracranial endovascular intervention codes and CPT codes 27280 and 27279 SI fusion codes. The RUC RAW is also flagging some category III codes with increased volume.
Medicare for All: Legislative Proposals and Relevance to Neurosurgery
Redi Rahmani MD, Jay Nathan MD, Anand Veeravagu MD

“Medicare for All” has become a rallying cry for health care reform on both ends of the political spectrum. Yet rather than representing a singular plan, multiple bills have been introduced in this 116th Congress under the umbrella concept of “Medicare for All,” proposing varying degrees of federally-sponsored health insurance. The most important aspect in understanding these bills and any new ones that may be proposed is to understand where they fall on the spectrum of coverage. The more drastic offer a new public program for all Americans to substitute for commercial coverage, while others follow a more graduated approach of a public option in addition to existing plans. The table below summarizes the introduced bills across five categories:

<table>
<thead>
<tr>
<th>Bill Number</th>
<th>Title</th>
<th>Sponsor</th>
<th>Committee of Jurisdiction</th>
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<tbody>
<tr>
<td></td>
<td>I. Single federal program as a comprehensive replacement</td>
<td></td>
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<tr>
<td>S. 1129</td>
<td></td>
<td>Sanders</td>
<td>Oversight and Reform, Armed Services</td>
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<td>Senate: Finance</td>
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<td></td>
<td>II. Single federal program with opt-out for qualified commercial plans</td>
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<td>Resources, Administration</td>
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<td>III. Federal buy-in option available via ACA marketplace</td>
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<tr>
<td>S. 3</td>
<td>Keeping Health Insurance Affordable Act of 2019</td>
<td>Cardin</td>
<td>Finance</td>
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<td>S. 1261</td>
<td></td>
<td>Merkley</td>
<td>Senate: Finance</td>
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<tr>
<td>S. 981</td>
<td></td>
<td>Bennet</td>
<td>Senate: Finance</td>
</tr>
<tr>
<td>H.R. 2085</td>
<td>The CHOICE Act</td>
<td>Schakowsky</td>
<td>House: E&amp;C</td>
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<tr>
<td>S. 1033</td>
<td></td>
<td>Whitehouse</td>
<td>Senate: HELP</td>
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<tr>
<td></td>
<td>IV. Expansion of Medicare eligibility with buy-in option</td>
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<tr>
<td>H.R. 1346</td>
<td>• Medicare Buy-In and Health Care Stabilization Act of 2019</td>
<td>Higgins</td>
<td>House: E&amp;C; Ways and Means</td>
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<tr>
<td>S. 470</td>
<td>• Medicare at 50 Act</td>
<td>Stabenow</td>
<td>Senate: Finance</td>
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<tr>
<td></td>
<td>V. State Medicaid buy-in option via ACA marketplace</td>
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<td>S. 489</td>
<td></td>
<td>Schatz</td>
<td>Senate: Finance</td>
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In the first category, companion House and Senate bills propose a single federal health insurance program for all Americans which is meant to replace and eliminate commercial plans. This program would offer lifetime enrollment beginning at birth. It gives the Secretary of Health and Human Services (HHS) strong discretion regarding benefits, including coverage for experimental drugs or devices. Only practitioners who are deemed eligible can bill this plan for their services, but Senator Sanders proposes increased flexibility for private contracting for coverage. In the House version, hospitals are paid a fixed amount quarterly to cover operating expenses, while the Senate version directs the Secretary to establish a fee schedule, similar to the existing schedule in Medicare. The federal health program would be paid for by merging budgets of all existing federal health plans.

The bill in category II also proposes a comprehensive national health insurance program, but rather than eliminating commercial plans, provides patients with an opt-out to keep employer-sponsored health plans meeting minimum requirements. Patients with income below the federal poverty line would face no premiums or cost-sharing. Under this bill, prior authorization would be prohibited. Practitioners are potentially eligible for student loan forgiveness, and they would be reimbursed via a fee schedule determined by the HHS Secretary. This plan would be financed through individual premiums and an 8% payroll tax on employers.

The four bills in category III propose a federal plan option offered through the Affordable Care Act (ACA) marketplace. Enrollment must be selected annually and follows marketplace rules. Cost sharing is regulated by ACA, with out-of-pocket maxima. Reimbursement rates would be determined by the Secretary, with ample room for experimentation with new payment models. These plans would be financed largely by premiums though would have start-up funds appropriated.

The two bills in category IV provide a Medicare buy-in option for older individuals not yet eligible for the current Medicare program, those aged 50-64 years old. Importantly, these plans do not cap out-of-pocket costs unless the individual qualifies for ACA cost-sharing subsidies. Practitioners and hospitals would be paid at current Medicare rates, and the cost of the new program would be covered by premiums.

Category V includes a bill with a Medicaid buy-in option that states can offer through the ACA marketplace. This bill focuses on uninsured individuals who are eligible to participate in the marketplace. Reimbursement for practitioners would follow Medicare rates for primary care and Medicaid for specialists.

For neurosurgeons, each step along this federal health plan spectrum offers potential advantages and disadvantages relative to status quo. A single comprehensive federal health plan (as in Categories I and II) unifies reimbursement policies and procedures, eliminating the need to track and respond to changing rules across many payers. However, that also eliminates competition among health plans to contract with neurosurgeons, increasing the monopsony power of the federal health plan to set reimbursement rates at lower levels and dictate a process of providing care. Comprehensive coverage increases patients’ financial access to neurosurgical care by insuring against potentially bankrupting costs, but if payment rates are set inappropriately low, neurosurgeons will reduce hours or leave practice, risking increased patient wait times even in emergencies. Given significant variability in these proposals brought to the same committees of jurisdiction, “Medicare for All” currently appears more as a match to ignite discussion than imminent law of the land. Yet it is critical for all neurosurgeons to be engaged in those deliberations and educate the public about what we need to continue providing safe, effective, and timely care to our patients.

FALL 2019 RESOLUTIONS

Resolution 1 was entitled “Augmenting the Allocation of Resources for Socioeconomic Education” which sought more support for socioeconomic educational opportunities for residents. In testimony it became apparent that this was in response to decreased funding for coding courses to make them complementary for residents. It passed in amended form.

Resolution 2 was entitled “Amendment of CSNS Rules and Regulations to allow for greater state representation”. This effort was attempting to address the problem of encouraging state representation within the CSNS amongst states without active state organizations through which delegates could be appointed. It was ultimately rejected because of concerns regarding proposing rules and regulations changes via a resolution, but was noted that this action was being taken through other means.

Resolution 3 dealt with “expanding subspecialty focused traveling fellowships during neurological surgery residency”. While there was debate that this should be more adequately dealt with through the subspecialty sections since the “fellowships” being discussed were subspecialty fellowships, ultimately a substitute resolution was passed in order to leverage the ability of the CSNS to speak for the younger neurosurgeons who might not have strong voices in their subspecialty sections.

Resolution 4 resolved to “Study the number and distribution of neurosurgeons in the United States”. This resolution was prompted by concerns over irregular distribution of neurosurgeons, leaving metropolitan areas “super saturated” and rural areas underserved. An amended resolution was ultimately adopted to investigate this issue.

Resolution 5 was titled “Prevalence of ambulatory surgery centers in neurosurgery practice”. This resolution seeks to explore the role and prevalence of ASCs in neurosurgical practice to help inform other neurosurgeons who may wish to become involved with ASCs. It was passed by substitute resolution.
RESOLUTIONS CONTINUED

Resolution 6 sought to develop a survey and position statement regarding “Surgical intervention in the reduction of opioid use” to deal with the growing opioid crisis. It was ultimately rejected because the Pain Section is already taking similar measures to deal with this important issue.

Resolution 7 sought to work with JCAHO to assess “Temporal and regional variability of thrombectomy rates across the US”. This resolution sought to identify how centers are responding to new evidence in stroke care, but was ultimately rejected since working with JCAHO was not felt to be feasible.

Resolution 8 dealt with “Further study of preparedness of neurosurgical graduates for practice” by requesting to partner with the ABNS for applicant POST data and assessing trends in complications, etc. While it was uncertain whether the ABNS would be open to sharing such data, it was overall felt reasonable to ask them given the relevance of practice preparedness of graduates on the CSNS.

Resolution 9 dealt with “Firearms access and at-risk neurosurgical patients.” Like multiple resolutions regarding firearms in the past, this resolution was the subject of significant debate. Ultimately, the resolution wording in favor of creating guidelines was refocused into creating a white paper regarding feasibility of counseling regarding gun safety in neurosurgical settings, which passed.

Resolution 10 sought support for “Improving price transparency for neurosurgical devices”. While it was well-recognized by the body that pricing of medical devices and supplies was a significant driver of healthcare cost and therefore very relevant to the CSNS, since pricing varies from hospital to hospital the particular wording of this resolution was not supported and it was ultimately rejected by the group.
RESOLUTIONS CONTINUED

Resolution 11 dealt with “Assessing the risks versus benefits of reprocessing surgical implants,” again recognizing the balance between cost and patient care. This resolution advocated to work with the Washington Committee and relevant Subcommittees and other organizations to explore this important issue, and was adopted.

Resolution 12 sought to study the scope of “On-call duty burden for practicing neurosurgeons” by studying call duties and practices across the spectrum of neurosurgery. While this topic generated a significant debate, it was ultimately rejected.
MEETING NOTES

Washington Committee Update

Dr. Stroink went over the structure and function of the Washington committee for the benefit of new members, being comprised of a number of committees and having liaisons from a number of partner organizations such as AANS/CNS joint sections, ABNS, CSNS, SNS, NeurosurgeryPAC, etc.

She went over the results of a policy agenda survey administered by the WC which was done to ensure that the WC agenda was representative of all rank and file neurosurgeons. Out of that survey: prior authorization relief was the most important issue. Other important issues to neurosurgeons nationally included medical liability, improving healthcare delivery systems, Graduate medical education funding, fair reimbursement, alleviating burdens of HER, continuing progress with medical innovations, and the opioid epidemic.

Regarding prior authorizations, She noted that a third of neurosurgeons go to “peer review” for up to 75% of their prior authorizations, of which the “peer” is not even of the same or similar specialty. She also noted that physicians and their staff spend the equivalent of at least 2 days per week doing prior authorizations. As a result, the WC has had dozens of meetings with senior CMS staff regarding ways to improve prior authorizations, leading to legislation regarding this important issue (HR3107). Currently this legislation has 95 co-sponsors and a companion bill in the senate is being worked on.

Regarding physician workforce shortage, she noted that by 2032 there will be a shortfall amongst all subspecialty and primary care physicians. Therefore, the WC has worked on promoting legislation creating new residency training slots, for which they have garnered bipartisan support (HR1763).

She noted that the global surgery payments delete codes could be eliminated, which places post service wRVUs at risk. The WC has advocated against making these changes and continue to value the post procedural work that we do as neurosurgeons.

The WC is supporting legislation for surprise medical billing (HR3502) which is modeled after a Fair Health New York Law dealing with the same issue. This again has bipartisan support.

Dr. Stroink invited all members to make use of the “CNS/AANS Legislative Action Center”, a website where personalized letters can be generated by neurosurgeons and sent out directly from the website:

http://cqrcengage.com/noc/Neurosurgery
LUNCHEON SPEAKER
Kristin Huntoon MD

Vanila M. Singh, M.D., MACM, chair of the Pain Management Best Practices Inter-Agency task force, and chief medical officer of the HHS Office of the Assistant Secretary for Health presented the recently released final report on acute and chronic pain management best practices. The Pain Management Best Practices Inter-Agency Task Force is a federal advisory committee established by the Comprehensive Addiction and Recovery Act of 2016.

The Task Force was created in the midst of a national opioid epidemic. However at the same time ~ 50 million adults in the United States experience chronic daily pain. Thus, the report emphasizes a balance approach of safe opioid stewardship by recommending more time for history-taking, screening tools, lab tests, and clinician time with patients to establish a therapeutic alliance and to set clear goals for improved functionality, quality of life, and activities of daily living. Medication disposal and safe medication storage are also emphasized for patient safety.

2019 CSNS Randy Smith Meritorious Award
This award, seeking to identify members who have provided exceptional service to the CSNS, is awarded only when a truly deserving individual is recognized. The recipient this year is Gary Simonds. Members will recognize the important role Dr. Simonds has had within the CSNS for many years, often being quite vocal on issues of patient safety and has put forth over 40 resolutions. In the words of Clarence Watridge, who presented the award, he is known for “always pushing us to be our best”. He has been a member of the CSNS since 2006, where he notes that he “enjoys being a thorn in the organizations’ side”. Dr. Simonds recently retired from his position at Carrillion Clinic in Roanoke VA, where he started a residency program. He has completed over 13,000 cases over the course of his career. Always an over achiever, he is spending his retirement playing 4 musical instruments and writing 3 novels.
**MEETING NOTES, con’t**

**Plenary Session Talks**

**Dr. Jake Godzik** gave a presentation regarding the creation of a virtual reality platform to assist in resident education of spinal procedures, which was the work product of a previous CSNS resolution. In addition to his engaging talk, he brought the equipment and staff working on the project at BNI so interested meeting attendees could try it first hand. He demonstrated via video what a VR placement of pedicle screws would be like, including tactile feedback of instruments, using fluoro, and complication management such as medial breaches in screw placement. Future directions for the technology amongst his group include developing VR methods for derotation maneuvers and rod contouring. He noted the importance of creating such new learning techniques due to generational changes amongst younger learners. This talk garnered significant interest amongst meeting attendees.

**Dr. Megan Jack** presented a summary of gainsharing. Gainsharing is a fiscal tool seeking to align physicians and hospitals for a common goal – generally to reduce cost and improve quality. Profit savings are then shared with the physicians. This phenomenon originated outside the medical field but was first utilized in the 1980s in medicine. In 1999 it was proposed that gainsharing may be illegal, temporarily freezing expansion of the phenomenon, but ultimately legal thought moved towards the legality of this measure, and it again began to expand within medicine in 2005. The ACA aimed to promote gainsharing in a limited fashion but the measures were not comprehensive. Gainsharing in neurosurgery so far has been uncommon, with most agreements being between cardiology or orthopaedics. However, some spine surgeons within multispecialty physician groups have engaged in gainsharing. This tends to limit certain operative choices, such as utilization of BMP outside of specific clinical circumstances to limit cost. At the current time, a number of CMS programs are sponsoring various forms of gainsharing, which may become more prevalent in the future.