



The Society of Thoracic Surgeons Health Reform Priorities

In May 2009, in advance of Congress passing the Patient Protection and Affordable Care Act (ACA) otherwise known as “Obamacare,” STS published [priorities for health care reform](#). As a new Congress and administration endeavor to reform or replace the 2010 law, the Society is articulating updated health reform priorities:

- [Ensuring Access to Health Insurance / Access to Health Care](#)
- [Supporting Evidence-based Health Care / Access to Data](#)
- [Promoting Value \(Quality / Cost\) in Health Care](#)
- [Promoting Training and the Adoption of Technology](#)
- [Prioritizing Team-based Care / Care Coordination](#)

Ensuring Access to Health Insurance / Access to Health Care

The Society believes that everyone deserves access to evidence-based, value-driven, life-saving care and all Americans have a right to health care coverage that provides access to needed health care services. This basic principle also is essential to a robust health insurance marketplace.

Currently, the ACA guarantees patient access to certain “essential health benefits.” These benefits include preventive services like lung cancer screening. Research has shown that evidence-based preventive services can save lives and improve health by identifying illnesses earlier, managing these illnesses more effectively, and treating them before they develop into more complicated, debilitating conditions; these services also can be cost-effective.¹

Heart disease is the No. 1 killer of Americans.² Access to health care that could prevent heart disease, such as blood pressure screening, cholesterol screening, diabetes screening, diet counseling, obesity screening, and tobacco use screening would save lives and prevent expensive interventions. Preventive care screenings identify modifiable risk factors for heart disease and detect signs of early heart disease. Eliminating risk factors and intervening in early disease are less costly than treating later stage heart disease.

Cancer is the second leading cause of death in the US, with lung cancer being the No. 1 cancer killer among both men and women. Deaths from lung cancer exceed the number of deaths from breast, colon, and prostate cancers combined.³ Access to low-dose computed tomography (LDCT) screening for lung cancer is an example of a preventive service currently covered by all private insurance companies and many state Medicaid plans as a result of the ACA; Medicare also covers LDCT screening in select patients. Screening for current and former smokers with LDCT is the only method proven to reduce lung cancer mortality in this high-risk population,⁴ and it also has been shown to be cost effective.

¹ Maciosek MV. Greater use of preventive services in U.S. health care could save lives at little or no cost. *Health Affairs*. 2010;29(9):1656-1660.

² Xu JQ, Murphy SL, Kochanek KD, Arias E. Mortality in the United States, 2015. NCHS data brief, no 267. Hyattsville, MD: National Center for Health Statistics; 2016.

³ American Cancer Society. *Cancer Facts & Figures 2017*. Atlanta: American Cancer Society; 2017.

⁴ The National Lung Screening Trial Research Team. *N Engl J Med*. 2011;365:395-409.

Access to LDCT screening for lung cancer is just one example of an evidence-based, value-driven service that was made possible under provisions of the ACA. STS supports patient access to all health care services that have been proven to be effective.

Supporting Evidence-based Health Care / Access to Data

The Society believes that the most important tool we have to fix a broken health care system is data. Any health reform effort must promote the secure transfer of information so that health care providers can analyze their performance, modify their practices, and provide the best possible patient care. Specifically, STS is calling on the Department of Health and Human Services to appropriately implement Section 105(b) of MACRA (Pub. L. 114-10). Section 105(b) requires the Centers for Medicare & Medicaid Services (CMS) to provide “qualified clinical data registries” (QCDRs) with Medicare data access for purposes of linking such data with clinical outcomes data and performing scientifically valid analyses or research to support quality improvement or patient safety. Providing QCDRs with regular and timely access to Medicare claims data is critical to the future of Medicare payment policy, which is now inextricably linked to quality improvement and resource use.

STS also has encouraged CMS to indicate “fact of death” by matching Medicare claims data with Social Security Death Masterfile (SSDMF) death data (or another source of vital statistics) before providing it to QCDRs. Patient outcomes information derived from the seamless combination of these data sources creates a powerful tool for tracking patient outcomes and resource use over an extended period of time. The implications of such longitudinal studies for quality improvement and value enhancement are dramatic. Failure to provide access to “fact of death” data makes complete and statistically valid longitudinal outcome analysis impossible.

The STS National Database was established in 1989 as an initiative for quality assessment, improvement, and patient safety among cardiothoracic surgeons. The fundamental principle underlying the STS National Database initiative has been that surgeon engagement in the process of collecting information on every case, combined with robust risk adjustment based on pooled national data and feedback of the risk-adjusted data provided to the individual practice and institution, will provide the most powerful mechanism to change and improve cardiothoracic surgery practice for the benefit of patients. The STS National Database has facilitated advancements in many aspects of health care policy, including public reporting of health care quality measures, facilitating medical technology approval and coverage decisions, and even saving money by helping cardiothoracic surgeons find more efficient and effective ways to treat patients. Clinical data from the STS National Database have been linked with administrative claims data from CMS on a number of occasions as a part of specific research requests or other collaborations. These discrete instances demonstrated important new ways to assess the effectiveness of treatment options and offered new avenues for medical research. The Society firmly believes that if a clinical/financial tool can be created by combining the STS National Database with claims data, hospitals and surgeons would be able to improve quality and generate savings in the hospital setting. Further, providing that level of support also will assist the system in reducing post-acute care costs by ensuring that providers have the ability to identify best practices that could potentially minimize, or even obviate, the need for post-operative skilled nursing facility services or inpatient rehabilitation.

Clinical data yield sophisticated risk-adjustment assessments, while administrative data provide information on costs, as well as long-term outcomes such as mortality rate, readmission diagnoses, follow-up procedures, and medication use. Since “value=quality/cost,” the combination of these clinical and resource use datasets will yield powerful information that can be used by providers to increase the value of health care that is delivered in the cardiothoracic domain. STS can generate risk models for cost, develop clinically associated risk/cost corridors, and help CMS to structure payment around the provision of high-quality care. This would allow continuous monitoring of quality as resource utilization is thoughtfully reduced, thereby identifying a cost/quality inflection point.

Promoting Value (Quality / Cost) in Health Care

As health care reimbursement continues to shift from a fee-for-service to a value-based model, organizations must continually evolve to ensure that the new model succeeds. Providing care in a value-based framework requires delivering evidence-based, high-quality care in an efficient, cost-effective manner and being transparent about outcomes. It has been suggested that health care value should be defined around the customer, set the framework for performance improvement, and be measured by outcomes and cost.⁵

Through private and public sector alignment, the move toward value-based care is succeeding. It has measurably improved health care quality and contributed to historically low costs. In cardiothoracic surgery, regional models (including examples in Northern New England, Virginia, and Michigan) are demonstrating that improved quality will reduce costs through the creation of evidence-based protocols using patients’ clinical information matched with administrative and cost data. With the STS National Database as a common data platform, the data infrastructure for assessing clinical outcomes already exists and can be combined with Medicare and other payer resource use data to promote value. True health reform efforts should support these initiatives by promoting access to data sources and supporting these collaborations.

Health reform efforts predominately focus on patient access to health insurance and health care providers. However, these policies will impact the implementation of concurrent value-based care initiatives. As such, the Society carefully will consider changes that impact patient access to adequate health insurance and hospitals’ indigent care policies. As providers (and/or hospitals) are being called upon to accept responsibility for longitudinal patient outcomes, it is critical that policies do not negatively impact their ability to manage the provision of quality care for all patients.

Promoting Training and the Adoption of Technology

A predicted shortage of physicians could exceed 100,000 by 2030, and although projections for individual surgical specialties vary, the projected shortfall of surgeons may reach 29,000 over the next decade.⁶ A progressive decrease in the number of physicians will affect everyone, but the vulnerable and underserved populations likely will experience the most severe impact. Programs like the Pediatric

⁵ Porter ME. What is value in health care? *N Engl J Med*. 2010;363:2477-2481.

⁶ Association of American Medical Colleges. 2017 Update: The Complexities of Physician Supply and Demand: Projections from 2015 to 2030. 2017.

Subspecialty Loan Repayment Program, authorized under the ACA to help to address these concerns, have never been funded. This leaves the country facing an influx of baby boomers who will need to access the health care system and a diminishing health care workforce.

Further, the practice of medicine is constantly evolving. A robust health care system not only values continuous learning on the part of the health care workforce but also the introduction and safe adoption of new technology. The 21st Century Cures Act laid the groundwork for more efficient processes that would bring new health care technology to the American people. It is imperative that all health care professionals work to ensure safe adoption of these new drugs and devices, as well as provide equitable access to life-saving treatments.

Prioritizing Team-based Care / Care Coordination

STS has been a longtime advocate of coordination across the spectrum of care, and the Society firmly believes that health reform efforts must prioritize access to team-based care. Many recent payment models have attempted to codify care coordination in a bundled payment. The “heart team,” which facilitates better, more coordinated, patient-centered care was federally mandated for reimbursement of transcatheter aortic valve replacement procedures and has been applied successfully to coronary artery disease management in many institutions. Under this approach, a patient who is identified as possibly needing revascularization or treatment for coronary artery disease is referred by a physician to a multidisciplinary team of professionals dedicated to understanding revascularization. The heart team reviews all pertinent data, sees the patient and family in consultation, and recommends the appropriate intervention and/or treatment for that individual.

The Society believes that payers should modify reimbursement structures so that each member of the heart team is compensated for his/her role in assessing each clinical case and developing a coordinated treatment strategy for each patient. The heart team has been described as including cardiothoracic surgeons, cardiologists, cardiac anesthesiologists, heart failure specialists, imaging specialists, and hospitalists. The collaboration also may include post-acute care and rehabilitation settings, provided that the risk attribution is appropriately adjudicated among the relevant providers.

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