The Society of Thoracic Surgeons

2017 Advocacy Priorities

Oppose Cuts to Lung Cancer Screening

- The CY2017 Hospital Outpatient Prospective Payment System Final Rule (HOPPS) finalized dangerous cuts to lung cancer screening reimbursement. The Centers for Medicare and Medicaid Services (CMS) should revise HOPPS to retain the structure of the various payment classifications as established in the 2016 HOPPS Final Rule.

Background

In February 2015, CMS issued a National Coverage Determination (NCD) for annual low-dose computed tomography (LDCT) screening of smokers and former smokers, thus increasing the number of screenings. However, the CY 2017 HOPPS proposed rule included 44% cuts to reimbursement for LDCT lung cancer screening of at-risk populations and 64% cuts to reimbursement for shared decision making sessions for tobacco cessation. Then, the Final Rule retained a 42% cut to the screening, though the cut to shared decision making was eliminated. STS and others are deeply concerned about the impact of this cut on patient access to lung cancer screening, which studies have shown is more or equally cost effective than other cancer preventions. Minority populations would be disproportionately affected by this cut.

Provide Access to Clinical Outcomes Data

- Support legislative and regulatory efforts to ensure that clinical registries can access Medicare claims data and all death data contained in the Social Security Death Master File (SSDMF) to facilitate outcomes-based research to help to improve health care quality and cost effectiveness.

Background

Beginning Nov. 1, 2011, the Social Security Administration (SSA) rescinded its policy of sharing death reports that it received from individual states. Currently, SSA will only share state-originated death information with Federal agencies. In December 2013, Congress passed additional restrictions on access to SSDMF data, imposing a certification program for legitimate users. This information has been of vital importance to physicians and researchers who want to evaluate the success of medical interventions and track other medical and public health related trends. Linking clinical registries to the SSDMF allows for the verification of "life status" of patients who otherwise would be lost for follow up after their treatment.

Additionally, Section 105(b) of the Medicare Access and CHIP Reauthorization Act (MACRA) requires CMS to provide Qualified Clinical Data Registries (QCDRs), such as the STS National Database, with access to Medicare data in order to link it with clinical outcomes data and perform research to support quality improvement or patient safety. CMS initially chose not to issue new regulations addressing Congress' directive as part of the Proposed Rule, stating that QCDRs can already access Medicare claims data through the Research Data Assistance Center (ResDAC) process. After an outpouring of concerned comments, in the Final Rule, CMS decided to treat QCDRs as quasi-qualified entities for purposes of obtaining access to Medicare claims data. Unfortunately, this will not provide them with the type of long-term and continuous access to large Medicare datasets to better track clinical outcomes over time as Section 105(b) of MACRA specifically directed.

2017 Advocacy Priorities

Support Congressional Oversight throughout MACRA Implementation

- Maintain oversight as CMS works to implement MACRA to ensure that the agency's interpretation of the law is consistent with Congressional intent.
    - Monitor MIPS
    - Monitor Alternative Payment Model (APM) Development & Implementation Processes

Background
STS is eager to help CMS shift away from fee-for-service and toward a paradigm that rewards physicians for quality of care, and we are grateful that CMS has indicated that reporting requirements for the Merit-based Incentive Payment System will be relaxed in year one of the program. However, we are anxious to see how the new program will be implemented. STS is also concerned that CMS will not seriously consider physician-designed alternative payment models recommended by the Physician-focused Payment Model Technical Advisory Committee (PTAC), particularly as the agency continues to create new mandatory APMs without any physician feedback.

Enact Meaningful Medical Malpractice Reform

- Support legislation like The Health Care Safety Net Enhancement Act and The Good Samaritan Health Professional Act in the 115th Congress

Background
Our country's inability to protect physicians from frivolous lawsuits while also maintaining patients' rights to seek redress for legitimate grievances has had a deleterious effect on STS members' ability to provide appropriate care. The prevalence of excessive tort claims against providers limits physicians' ability to provide needed health care services, affects the cardiothoracic surgical workforce (as increasing numbers of medical students choose careers in fields with lower liability insurance costs), makes the practice of defensive medicine and the erosion of patient-centered care far more prevalent, and drives up the cost of health care nationwide.

STS supports reforms of medical malpractice laws to help lower the costs and reduce incidence of defensive medicine throughout the health care system, while ensuring that patients injured by true malpractice are compensated fairly for their losses.

Address the Cardiothoracic Surgery Workforce Shortage

- Support legislation that:
    - Prevents the loss of thoracic surgery training slots/raises the cap on Medicare-supported residency positions;
    - Provides for loan forgiveness and/or deferred loan repayment for specialties with long training periods;
    - Supports and promotes medical simulation technologies;
    - Examines the potential benefits of 6-year, integrated cardiothoracic residency programs; and/or
    - Examines geographic and economic factors leading to the lack of fill in cardiothoracic residency programs.

Background
The number of practicing cardiothoracic surgeons is decreasing, and that decline is expected to continue over the next decade as more than half of the current cardiothoracic surgeon workforce is 55 years and older. Presently, there is approximately one cardiothoracic surgeon in the United States per 62,577

people. This shortage will be compounded by the fact that the Medicare-age population – those most frequently affected by cardiovascular disease – is expected to double by 2030. Cardiovascular disease accounts for more than one-third of the deaths in the United States.

There was a dramatic reduction (nearly 40%) in the number of applications for cardiothoracic residency positions from 2004 to 2008. Further, the fill rate for residency slots is also on the decline. For example, in 2010, there were 84 slots filled out of 116 available (72%).