



**AMERICAN ACADEMY OF
OTOLARYNGOLOGY–
HEAD AND NECK SURGERY**

January 16, 2015

The Honorable Fred Upton
Chairman, Energy and Commerce Committee
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member, Energy and Commerce Committee
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Upton and Ranking Member Pallone:

Thank you for the opportunity to provide comment and assist in your Committee's efforts to review, and potentially reform, the structure of Graduate Medical Education (GME) in the United States. The American Academy of Otolaryngology–Head and Neck Surgery (AAO-HNS) is the national medical association of physicians dedicated to the care of patients with disorders of the ears, nose, throat (ENT), and related structures of the head and neck. Given the forecast for increasing physician shortage areas, we look forward to working with Congress to ensure the continuity of a robust pipeline for training physicians/surgeons.

The AAO-HNS welcomes the review and possible improvement of the existing GME funding model. However, we feel strongly that any new methodology for GME funding should be guided by the following principles.

- **Reforms should focus on creating a system that produces the optimal workforce of physicians to meet our nation's medical needs.** It is critical that the patient population has access to consistent, high-quality care across the nation.
- **The practice of medicine and delivery of healthcare services is dynamic and continually evolving.** The resultant healthcare delivery system may in fact create workforce needs that differ markedly from today's needs. Therefore, the GME funding mechanism should be nimble enough to adjust rapidly to this changing medical landscape. In addition, methodologies to project workforce needs will need to be developed and continually refined as data becomes available. This methodology should be used to distribute funding in a transparent way that meets workforce needs, not vested political or financial interests.
- **There must be accountability built into the system, not only to certify that funds are being spent appropriately to support the training of physicians, but also to ensure quality and the readiness of the physicians emerging from training.** A combined governance system with articulated goals and measured outcomes is needed.
- **Programs that produce high quality graduates in an efficient manner, and consistent with workforce needs, should be rewarded through financial incentives or higher levels of support.** Similarly, funds should be set aside to support innovation in GME, which will incentivize higher quality training.

2014-2015 ACADEMY BOARD OF DIRECTORS

OFFICERS

Gayle E. Woodson, MD
President
Springfield, IL

Sujana S. Chandrasekhar, MD
President-Elect
New York, NY

Gavin Setzen, MD
Secretary/Treasurer
Albany, NY

Scott P. Stringer, MD
Secretary/Treasurer-Elect
Jackson, MS

James C. Denny, III, MD
Executive Vice President and CEO
Alexandria, VA

IMMEDIATE PAST PRESIDENT

Richard W. Waguespack, MD
Birmingham, AL

AT-LARGE DIRECTORS

Carol R. Bradford, MD
Ann Arbor, MI

Paul T. Fass, MD
Miami, FL

Karen T. Pitman, MD
Gilbert, AZ

Michael D. Seidman, MD
West Bloomfield, MI

Michael G. Stewart, MD MPH
New York, NY

Duane J. Taylor, MD
Bethesda, MD

Kathleen L. Yaremchuk, MD, MSA
Detroit, MI

Jay S. Youngerman, MD
Plainview, NY

BOARD OF GOVERNORS

Wendy B. Stern, MD
Chair
North Dartmouth, MA

David R. Edelstein, MD
Chair-Elect
New York, NY

Peter Abramson, MD
Past Chair
Atlanta, GA

SPECIALTY SOCIETY ADVISORY COUNCIL

Richard M. Rosenfeld, MD, MPH
Chair
Brooklyn, NY

Kathleen L. Yaremchuk, MD, MSA
Chair-Elect
Detroit, MI

COORDINATORS

Jane T. Dillon, MD, MBA
Socioeconomic Affairs
Rolling Meadows, IL

Robert R. Lorenz, MD, MBA
Practice Affairs
Cleveland, OH

EX-OFFICIO

Susan D. McCammon, MD
Chair, Ethics Committee
Galveston, TX



- **Funding for GME activities should be adequate, stable, predictable, broad-based, and dispersed in a transparent fashion.**

Background

Otolaryngology–Head and Neck Surgery is considered a surgical subspecialty, but unlike most other surgical subspecialties, has no medical counterpart. Accordingly, otolaryngologist–head and neck surgeons provide long-term management of medical problems (such as sinusitis, dizziness, and hearing loss), as well as surgery of the head and neck and skull base, and emergency care for such problems as severe nosebleeds, injuries to the head and neck area, sudden hearing loss, and gunshot wounds to the neck. Because of the diversity of the specialty, many otolaryngologists are sub-specialized into such areas as pediatric otolaryngology, ear surgery, nasal and sinus surgery, sleep disorders, allergy, and head neck tumor surgery.

The AAO-HNS, through its Physician Resources Committee, has carefully studied the projected workforce needs for the specialty using multiple sources and databases. There are approximately 10,800 otolaryngologists in the United States (roughly 1:27,000 population, which is significantly less than most European countries and Japan), and the number of *patient care* FTEs is even lower as a result of administrative duties, research, part-time practice, etc. Additionally, the average age of otolaryngologists is increasing. Based on projected population expansion alone, we will have a significant shortage of physicians within the specialty by 2025 (based on current modeling) even allowing for a significant growth of mid-level providers and deferred retirement. Furthermore, with the aging population, there is a marked increase in demand for otolaryngology services, particularly in areas such as the management of hearing loss, swallowing and voice problems, obstructive sleep apnea, and dizziness or balance disorders.

AAO-HNS Response to Questions Posed in the Committee’s Open Letter

1. What changes to the current GME financing system might be leveraged to improve its efficiency, effectiveness, and stability?

Expansion of the physician healthcare pipeline is essential to meet the nation’s healthcare needs with modifications guided by accurate and current workforce analyses. This would also necessitate removing the existing cap on residency slots. An aging physician population within otolaryngology and an expanding and aging patient population make this especially important within our specialty.

However, while these efforts are underway, ensuring stability in the current GME funding system is critical to avoid reduction of residency training positions, thereby further reducing the physician pipeline. Improved transparency and accountability associated with the dual role of Indirect Medical Education (IME) funding are also key to this process.

In addition, a GME financing system that acknowledges and promotes the most efficient use of a trainee’s time could lead to revision of training programs to eliminate unnecessary years of training in areas that would not be utilized by the trainee in his/her career. This has been piloted by the American Board of Surgery and the Accreditation Council for Graduate Medical Education (ACGME) for the training of vascular and thoracic surgeons for a decade with good results, and is a model that could be utilized to streamline the training of other medical and surgical specialists.

While further study would be helpful to evaluate and improve training efficiency, funding for such an analysis should be provided outside of current IME funds to avoid reductions in training given projected physician shortages. Such studies and pilot programs require a framework guided by educational rather than political objectives, and establishing and subsequently rewarding “best practice” training programs would ultimately result in better trainees. Also, as technology progresses in the area of simulation training, additional funding would be valuable to improve the quality of graduating trainees. Finally, “transition to practice” programs following residencies could also raise quality parameters.

2. There have been numerous proposals put forward to reform the funding of the GME system in the United States. Are there any proposals or provisions of proposals you support and why?



Several bills introduced in the 113th Congress, including the *Resident Physician Shortage Reduction Act* (S. 577/H.R. 1180) and the *Training Tomorrow's Doctors Today Act* (H.R. 1201), propose modest expansion in GME training to reduce the anticipated physician shortage. These bills have received wide support from physicians and other organizations, including groups representing primary care physicians and specialists. Under these bills, half of newly available residency slots would be dedicated to “shortage specialty” residency programs as identified by an independent third party. H.R. 1201 also includes provisions to establish accountability and transparency measures in accordance with recommendations issued by the Medicare Payment Advisory Commission (MedPAC). The AAO-HNS welcomes the opportunity to work with Members of Congress to advance these and/or new legislative proposals relating to GME in the 114th Congress.

Overall, any proposals advocating new or augmented funding mechanisms should be based on data from well-designed workforce studies funded in addition to current GME funding. The new system must be transparent and accountable and allow flexibility. As practice and treatment models continue to evolve, training programs must evolve, too. Programs must also have the tools available to ensure physicians are properly trained and able to provide the highest quality care to a patient population that is evolving as well. Only a nimble system will be able to adapt alongside the changing medical practice. Funding should be increased, consistent and supportive of quality and innovation. While a broad-based funding system would seem to have merit, the “public good” accomplished by federal funding should be maintained and commercial interests not be allowed to influence the underlying principles associated with the provision of high-quality care.

3. Should federal funding for GME programs ensure training opportunities are available in both rural and urban areas? If so, what sorts of reforms are needed?

While there is clearly a significant geographic maldistribution of physicians, this issue should not be addressed solely through GME funding. Indeed, there is evidence that factors beyond GME financing may be preventing expansion in chronically underserved areas.

Current policy already incentivizes GME expansion into rural areas. For example, Critical Access Hospitals (CAHs) are reimbursed at 101 percent of reasonable costs while teaching hospitals receive a formula-based payment which covers only part of the institution’s direct costs. Additionally, the 1996 residency caps were readjusted in 1997 to allow for re-expansion in rural hospitals. However, these measures have not necessarily been successful in addressing the maldistribution.

Programs allowing for regionalization and additional funding for rural hospitals affiliated with a training center would open more residency slots and potentially improve workforce problems in rural areas while maintaining high-quality training. As medical schools expand into smaller metropolitan areas it makes sense to also expand GME training to those areas. Funding for the Area Health Education Center program (AHEC) should be continued. However, even with programs like this, the added costs associated with becoming a teaching hospital and the ongoing administrative burden of operating a high-quality training program make the cost daunting for many institutions. In addition to providing the appropriate infrastructure for maintaining a program, it is unclear whether such hospitals have the necessary volume and diversity of patient cases to offer ample opportunities to ensure a high-quality, well-rounded educational experience. Therefore, we also support concepts of loan forgiveness, National Health Service Corps, and tuition sponsorship as additional measures to attack the problem.

4. Is the current financing structure for GME appropriate to meet current and future healthcare workforce needs?

The current financing structure for GME does not meet the current and future healthcare workforce needs due to the predicted number of physicians in training to care for the growing U.S. population, the complexity of medical illnesses, and the realities of specialization and subspecialty training that is required to provide high-quality care.



In contrast to the 2014 Institute of Medicine (IOM) report, we believe that the 1996 residency cap (Medicare Balanced Budget Act) has indeed significantly limited the number of otolaryngology residency training slots, and the projected rate of growth of residency training slots will be insufficient to provide for future needs. There are projections indicating there will be a shortage of physicians, both primary care and specialists, approaching 1.5M by the year 2025. Any reduction or instability in funding for GME is likely to result in a decrease in residency training slots, further impacting the projected otolaryngology workforce shortage. This assumption is supported by an August 2013 survey of GME program directors by the ACGME. In this survey 83 percent of respondents were already engaged in leadership level discussions about how they would reduce residency positions in both primary and specialty care if Medicare GME support were reduced.

In addition to the need for stable funding, the AAO-HNS would also support greater transparency, oversight, and accountability of GME funding. Although the potential for improved efficiency in residency training should be explored, as noted above, the funds required to study these options should be provided from sources other than current IME funding. Redirecting the current IME funding into a transition fund, as suggested by the IOM report, would erode the financial stability required for academic medical centers to ensure a consistent source of residents entering the workforce.

i. Should it account for direct and indirect costs as separate payments?

It is important to recognize that IME funding was not established entirely as a method of payment for GME. In fact, in 1983, a House Ways and Means Committee Report and a Senate Finance Committee Report stated IME was created because of concerns about the inability of Medicare coding to “account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with teaching of residents.”

Similarly, the 1983 House Ways and Means Committee report stated “the adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals.” Thus IME, while helping to cover the costs of resident training not covered by Direct Medical Education (DME) payments, also provides important funding for the type of safety net medical care provided by academic medical centers which remain poorly accounted for in the Diagnosis Related Group (DRG) reimbursement system. Since there is confusion with regard to the use of these funds, greater accountability and transparency is required, while at the same time avoiding the acute destabilization of an important source of funds for both resident training and safety net healthcare.

The AAO-HNS would advocate for spreading these costs more broadly throughout the healthcare system. It is important to recognize that Medicare itself only covers its share of the costs, less than a quarter of the direct costs that teaching hospitals incur, and that the current mechanism for financing GME does not reflect the full spectrum of entities benefiting from the products of residency training.

a. If not, how should it be restructured? Should a per-resident amount be used that follows the resident and not the institution?

Although the concept of having the funding for residency training follow the individual, rather than the institution, appears attractive at first glance, this could create significant instability within the system’s infrastructure. It would also adversely impact the training of other residents within a given program. Many educational and administrative expenses involved in resident training are institutionally based and provide the required infrastructure for efficient and cost-effective residency training. It should also be noted that DME funds are, to some extent, already aligned to an individual resident in that a resident in their “initial residency period” (IRP) is counted as 1.0 FTE, whereas a resident beyond their IRP is only counted as 0.5 FTE. Similarly, physicians who decide to retrain in another specialty are counted as 0.5 FTE. A system involving regional training programs, however, might benefit from some form of resident-specific funding if there was additional funding for the secondary site, thereby allowing the primary site’s infrastructure to be maintained.



b. If so, are there improvements to the current formula or structure that would increase the availability of additional training slots and be responsive to current and future workforce needs?

The ACGME has already instituted significant changes in GME, including transitioning toward an outcomes- and competency-based accreditation for resident training. A transition fund, developed without adversely impacting current IME funding, could accelerate this process, enabling additional study of potential efficiencies, residency training requirements, and future national physician needs. In addition, pilot programs aimed at reducing residency training times could be established and studied to enable additional physicians to be trained without adding to this segment of healthcare costs.

ii. Does the financing structure impact the availability of specialty and primary care designations currently? Should it be moving forward?

Evidence suggests that factors other than GME financing are more powerful in influencing the specialty mix of physicians than educational funding adjustments. As noted in the IOM report “Health care reimbursement and the organization of healthcare services, for example, are more important than GME in determining the makeup and productivity of physician supply.” Prior attempts to manipulate specialty selection through Medicare GME payments have not been successful.

5. Does the current system incentivize high-quality training programs? If not, what reforms should Congress consider to improve program training, accountability and quality?

U.S. residency training programs and U.S. teaching hospitals have long served as a model for physician training around the world. The accreditation process involving the ACGME, Residency Review Committees, and respective specialty boards is transitioning to outcomes-and competency-based care rather than a time-based system.

Unfortunately, the availability of adequate quality-related data is a stumbling block for quality-based improvements both in residency training programs, as well as the post-graduate practice of medicine. Congress should fund the \$100M dollars allotted in the ACA that would help medical specialties produce the necessary data through registries. Smaller medical specialties, such as otolaryngology, currently cannot fully afford the upfront and ongoing resources required to develop a fully integrated registry that could help serve this need. Not only would collection of this data be valuable on a broader scale, i.e. to enhance tracking of quality improvement in practice for numerous programs, but it would also help improve training programs and reward those who excel. We would not, however, favor financial penalties in this type of program.

6. Is the current system of residency slots appropriately meeting the nation’s healthcare needs? If not, please describe any problems and potential solutions necessary to address these problems?

The current system is widely projected to create deficits of providers, across all specialty designations, by the year 2025. The cap placed on residency positions does not allow training of the additional residents needed to care for an expanding and aging population. Seniors require more physician visits and a greater range of physician services than any other age group, and, as noted previously, this is particularly important within the field of otolaryngology as older patients present with hearing deficits, balance disorders resulting in falls, and problems with voice and swallowing. This, in conjunction with the productivity decline associated with EHR usage, exacerbates the projected shortages. Any overhaul of the GME system should include elimination of the cap on residency training positions. As noted above, reliable, well-designed workforce studies should be undertaken utilizing additional funding streams and be used to guide the future allocation of training positions.

Additionally, some issues which adversely affect residency training could be addressed with technical fixes as noted below:

- Prevent accidental triggering of hospital cap/per resident amount (PRA)

Under current Medicare rules, if a non-teaching (community) hospital accepts medical resident “rotators,” it risks receiving substantially lower funding from the Medicare program if it ever decides to become a teaching hospital.

- Eliminate the three-year rolling average rules

Under current rules, Medicare DME and IME payments are calculated based on a “three-year rolling average” of the number of medical residents being trained in a given teaching hospital, rather than the current number of medical residents being trained in a given year. Eliminating the rolling average rules would allow a teaching hospital to be reimbursed for the actual number of trainees in a given year.

- Count all resident time

CMS requires teaching hospitals to document the amount of time residents spend in each type of training activity (e.g., research-related, certain didactic training) for purposes of calculating DME and IME payments. Given that all these training activities are required as part of the medical resident training program, there is little added value in requiring such time accounting, which results in an unnecessary administrative burden.

- Allow redistribution of closed program residency slots

Under current law, if a teaching hospital closes, the slots associated with that hospital are permanently redistributed to other teaching hospitals based on established criteria. However, medical residency slots at a teaching hospital that closes all its training programs, but does not close itself, are not eligible for re-distribution to other facilities. Congress should amend current Medicare rules to allow medical residency slots from hospitals that close all residency programs, but otherwise remain open, to be allocated to other hospitals.

- Resolve issues with “initial residency period” and residents switching programs

Under current law, the length of time Medicare will pay for medical residency training is tied to the expected length of training for a given specialty. Because different specialties have different residency requirements, residents who change specialties, even after one year, often have trouble convincing hospitals to accept them into their programs.

- Permit new urban teaching hospitals to participate in affiliation agreements

Under current law, any urban teaching hospital that began training residents after 1996 may not enter into a Medicare GME affiliation agreement to “loan” its slots to other hospitals. This prevents new urban teaching hospitals from collaborating with community partners. To facilitate such collaboration, CMS should allow new urban teaching hospitals to enter into GME affiliated groups after being a teaching hospital for five years.

7. Is there a role for states to play in defining our nation’s healthcare workforce?

Both state and federal governments should play a role in developing the nation’s healthcare workforce. However, national GME standards should be maintained and included in any state-led projects.

Unfortunately, there has been a steady decline in the number of states that provide GME support through their Medicaid programs as they wrestle to produce balanced budgets. Providing new incentives for states to invest already scarce state dollars in physician training through their Medicaid programs could help to bolster support to community health centers without undermining similar investments and facilities serving larger numbers of Medicare beneficiaries. In addition, states are well-positioned to complete workforce studies that more accurately delineate their specific needs. Currently, there are state-related GME projects in Georgia, California, Utah, and North Carolina that may serve as models for the future.



Conclusion

Again, thank you for the opportunity to provide input on your efforts to identify and explore possible reforms to the current GME structure. In the coming weeks/months, the AAO-HNS and others in the physician community stand ready to assist in any way possible. If you have questions regarding the AAO-HNS positions stated above, please contact Megan Marcinko, Senior Manager for Congressional and Political Affairs, at 703-535-3796 or mmarcinko@entnet.org.

Sincerely,

James C. Denny, III, MD
Executive Vice President and CEO

Cc: House Energy and Commerce Committee Members