January 16, 2015

Committee on Energy and Commerce
2123 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Pitts, Ranking Member Pallone, Ranking Member Green, and Representatives DeGette, McMorris Rodgers, Welch, Griffith, and Castor:

On behalf of children’s hospitals and the patients and families they serve, the Children’s Hospital Association thanks the members of the Committee for turning a spotlight on the important issue of our nation’s system for financing graduate medical education (GME). We are grateful for the opportunity to comment on current structures of support for training the pediatric workforce and possible future directions that could strengthen the system to the benefit of all children.

**Background**

This examination is extremely timely. Our nation’s commitment to children’s health care lags behind our investment in adults with respect to workforce training.

- Since 2000, the national population of children has grown 3 percent, increasing from 72.3 million to some 74.2 million today. At the same time, the health care needs of the child population are increasing. The number of children with complex medical conditions is growing at a faster rate than the overall child population, requiring an increased number of specialty care providers.

- But funding to train the doctors to serve these children has not kept pace. While children under 18 currently comprise about 23 percent of the U.S. population, only 9 percent of federal support for GME is targeted toward training pediatric providers (combining CHGME and Medicare funding for pediatric residents).
The current financing structures for GME are not adequate to meet current and future pediatric health workforce needs. Freestanding children’s hospitals, which train approximately half of all pediatricians and pediatric specialists, receive almost no federal GME support through Medicare. At the same time, the Children’s Hospitals Graduate Medical Education (CHGME) program, a discretionary program and the primary source of support for training at these hospitals, has suffered major cuts in recent years; CHGME funding has decreased 17 percent since FY 2010, from $317.5 million to $265 million in FY 2015.

Additionally, on a per-resident basis, the support provided by CHGME continues to lag far behind that provided by Medicare. At current funding levels, the average CHGME payment per full-time equivalent (FTE) resident represents only 43 percent of what Medicare provides to support training in general acute care teaching hospitals.

If we do not act to sustain and strengthen the pediatric workforce, we face the potential of exacerbating existing pediatric workforce shortages, particularly among specialists, that will put access to care at risk for children.
Summary of Recommendations

As a nation, our goal should be to ensure that no child lacks access to high quality medical care. A robust pediatric workforce is vital to achieving this goal. GME training is a public good essential to ensuring the availability of health care for all children. It is vitally important that the federal government take steps to strengthen its investments in children’s health care by bolstering GME support for pediatric training.

1. Congress should fully fund the Children's Hospitals Graduate Medical Education (CHGME) program at its authorized level of $300 million through the annual appropriations process.

2. At the same time, lawmakers should explore alternative models of GME support for training the pediatric workforce. Specifically, Congress should consider approaches that provide stable mandatory funding streams supporting pediatric GME in freestanding children's hospitals at a level similar to GME programs funded through Medicare.

3. Congress should continue to provide strong support for the Medicare GME system in order to strengthen pediatric training at children's hospitals embedded within larger health systems that are eligible to receive Medicare GME.

Explanation of Recommendations

1) Congress should fully fund CHGME at its authorized level through the annual appropriations process.

The CHGME program supports the training of approximately half of all pediatric trainees in the United States. Although the 54 hospitals that currently receive CHGME funding comprise less than 1 percent of all hospitals, they train 49 percent of all pediatric residents - more than 6,000 annually - including 45 percent of general pediatricians and 51 percent of pediatric specialists. Since 1999, the CHGME program has accounted for more than 74 percent of the increase in the number of new pediatric specialists trained nationwide. The program also provides essential support for primary care, as nearly 60 percent of residents at CHGME hospitals are training in general pediatrics.

Congress has reauthorized CHGME three times, each time with broad bipartisan support. On April 7, 2014, the president signed S. 1557, “The Children's Hospital GME Support Reauthorization Act of 2013”, which reauthorizes the program through FY 2018. We wish to once again extend our appreciation for the leadership of Reps. Pitts and Pallone in seeing CHGME reauthorization legislation through the 113th Congress. We also recognize the committee’s recent bipartisan record of achievement in other areas affecting children’s health, including pediatric research, where the pediatric workforce is fundamental to the success of these initiatives.

While much has been achieved under CHGME, much remains to be done, as serious pediatric workforce shortages persist, most acutely among pediatric subspecialties. These shortages affect children’s access to timely, appropriate care. Certain pediatric specialties have wait times of 14.5 weeks or more compared to the two week standard for accessing services.iii Additionally, there are localized shortages of pediatric primary care (such as certain rural areas). If current funding streams are not maintained and strengthened, the progress achieved under CHGME will be at risk.
The persistence of these shortages underscores the importance of CHGME. There are no other adequate sources of support for training taking place in free-standing children’s teaching hospitals. Freestanding children’s hospitals receive little or no GME funding from Medicare. Other funding streams, such as Medicaid GME – which has been significantly reduced or eliminated in many states - or competitive grants, are not available to many children’s hospitals and cannot come close to supporting training on the scale necessary to meet workforce needs. The decline in CHGME funding in recent years jeopardizes the ability of children’s hospitals to train enough providers to meet children’s needs and can force these hospitals to limit training experiences and patient care services, including activities promoting the normal development of children in the communities they serve.

The potential effects of not strengthening support for pediatric training will be felt by children and their families, including those with rare and complex conditions. CHGME support has allowed children’s hospitals to develop training programs in highly specialized disciplines that target the unique needs of children, including, for example, pediatric surgical oncology, radiation oncology, pediatric pathology and bone marrow transplantation. Only a small number of institutions provide training in some of these areas. Without strong CHGME support, it would be difficult for children’s hospitals to maintain support for programs focused on these subspecialties which are crucial to providing the highest quality of care for children facing rare and complex medical conditions. There are also several pediatric specialties (e.g. endocrinology, nephrology) that are at risk of sustaining tremendous losses as the current workforce retires and not enough new specialists are trained.

To serve the needs of America’s children, it is imperative that Congress fully fund CHGME at its authorized level, currently $300 million annually.

2) Congress should consider GME structures that provide stable mandatory funding streams for pediatric GME in freestanding children’s hospitals.

Increasing support for CHGME is only one step towards strengthening the pediatric workforce. CHGME, originally, was created to address a gap in pediatric training. The program as it exists was not necessarily envisioned as an end point, but rather a bridge until a more comprehensive solution could be achieved. To provide the greatest benefit to children’s needs, a system of federal support for graduate medical education should be built on key pillars:

- Funding should be predictable
- Funding should be stable
- Funding should be adequate at the aggregate level
- Funding should be adequate at the per-resident level.

To further strengthen the pediatric training system to align with these tenets, Congress should consider alternate models that would create a mandatory funding stream to support pediatric graduate medical education at independent children’s hospitals.

In 2014, the Institute of Medicine (IOM) issued a report entitled, “Graduate Medical Education That Meets the Nation’s Health Needs.” The report noted that the current system that ties the vast majority of federal GME support to Medicare patient volume, “systematically disadvantages children’s hospitals” and other training sites that care for
non-elderly patients. By disadvantaging the sites that train pediatric providers, the system disadvantages children’s health. Why would our nation make the training of the doctors who care for our children any less of a priority than the training of the doctors who serve adults?

Unlike Medicare GME, which is an entitlement program, CHGME must be reauthorized periodically and is funded through the annual congressional appropriations process. Currently the program is reauthorized through 2018 which speaks to the bipartisan consensus on the value of the program and its mission. However, reauthorization carries a degree of uncertainty and the annual appropriations process adds an additional layer of uncertainty. As the IOM report further states:

“The HRSA CHGME program directs some funding to children’s hospitals, but the funding is unpredictable because it is subject to the annual appropriations process. This undermines the capacity of the affected training programs to plan beyond the fiscal year…”

“Stable funding is also essential to ensuring a meaningful role for residents in patient care delivery, which is the foundation of our educational model. Relying on a federal program that depends on discretionary appropriations would introduce significant risk and considerable uncertainty for training programs.”

Each year, established training programs are unsure if sufficient funds will be available to continue their programs. Since the duration of pediatric GME training is three to six years for each trainee, trainees in these children’s hospitals potentially could lose their positions if adequate funds are not appropriated. This lack of stable funding also is a disincentive for children’s hospitals to maintain or expand current training programs.

Additionally, because total funding for CHGME is capped, children’s hospitals receive considerably less on a per-resident basis than adult hospitals receive from Medicare GME. In FY 2015, CHGME funding was set by Congress at $265 million. Analysis commissioned by the Association shows that at that level, the average CHGME payment per full-time equivalent (FTE) resident equates to $58,147, which on a per-resident basis is just 43 percent of Medicare support for training in general acute care teaching hospitals. If CHGME funding remains at 2015 levels, by 2018, per-resident CHGME support will decline to 37 percent of Medicare support. Even if Congress were to fully fund CHGME up to its authorization of $300 million this would raise CHGME to approximately $66,330 per resident, or only 52 percent of the level of support provided by Medicare GME.

Children’s hospitals incur significant costs to subsidize their teaching mission because of this inequity between CHGME and Medicare GME. These costs can be as high as $40 million annually in some children’s hospitals. These additional costs are particularly difficult to bear given that children’s hospitals face the added financial pressures associated with being large Medicaid providers. On average, over half of a children’s hospital payor mix is Medicaid, which on average pays approximately 35% less than Medicare.

The IOM recommends that training slots at freestanding children’s hospitals should receive the same average per-resident amount as adult hospitals. While children’s hospitals have concerns about many specific aspects of the IOM’s reform proposals to reconfigure federal support for GME, we applaud the recognition of the challenges the current system creates for children’s health, and the recommendation for parity between children’s and adult teaching hospitals.
The Children’s Hospital Association believes it is important that lawmakers pursue a two-track approach of continuing to support the existing CHGME program while at the same time exploring new models. The President’s FY 2015 budget, by contrast, proposed eliminating funding for CHGME and incorporating support for training at independent children's hospitals into a new competitive grant program, funded from Medicare trust fund dollars, but with only $100 million set aside specifically for children’s hospitals in FY 2015 and FY 2016. While children’s hospitals support identifying a mandatory funding stream to support training in independent children’s hospitals, to simultaneously propose cutting funding and eliminating support for a program with a proven track record of success, would unnecessarily put at risk gains that have been made for children’s health.ix

3) Congress should continue to provide strong support for Medicare GME

Medicare GME funding is vital to supporting the pediatric workforce. Approximately half of pediatric residents are trained in children’s hospitals that are part of adult system and eligible to receive Medicare GME. We urge Congress to continue to provide strong support for the Medicare GME system.

Congress should avoid cuts to Medicare GME funding, including cuts to Indirect Medical Education (IME) payments. Cuts of this nature would increase financial pressure on training institutions. Preserving existing and reliable Medicare support for teaching hospitals is vital to efficiently and effectively train the next generation of physicians without jeopardizing the equally important research and clinical missions at academic medical centers.

In addition, Congress should consider steps to bolster the number of physicians trained by Medicare. Residency training positions at teaching hospitals are limited by the cap on Medicare support imposed by the Balanced Budget Act of 1997. Hence, while demand for health care services grows, there is not commensurate growth in the supply of trained physicians, leading to shortages in some specialties and geographic areas. Lifting the cap on Medicare-supported residency positions would enable teaching hospitals to begin expanding their programs to keep up with clinical demands in primary and specialty care.

Conclusion

Now is not the time to take a step backwards in pediatric medicine. Our nation must support vital investments in the infrastructure to improve children’s health. Individual children’s hospitals and the Association are available to discuss these issues with Committee and staff in further detail. We look forward to collaborating with Congress to achieve sustainable, predictable, and equitable support for graduate medical education to ensure a strong foundation for children’s health care across the country for years to come.

Very best regards,

Mark Wietecha
President and CEO
Children’s Hospital Association


Children’s Hospital Association Fact Sheet, “Pediatric Specialist Physician Shortages Affect Access to Care”, 2012.

Children’s Hospital Association fact sheet, “Percentage of Pediatric Specialists Trained at CHGME Hospitals”, 2012.

Institute of Medicine, “Graduate Medical Education That Meets the Nation's Health Needs”, pages 9, 101

Institute of Medicine, page 101.

“Comparative Analysis of GME Funding for Children’s Hospitals and General Acute Care Teaching Hospitals”

Institute of Medicine, page 157.

Children's hospitals have additional concerns with other aspects of the Administration's proposal. The proposal would continue to underfund pediatric training as the annual the amount proposed represents only approximately 40% of current funding. Furthermore, competitive grants limited in duration and available only to a limited class of recipients would fall short of the support needed to preserve and strengthen the fragile pediatric pipeline.