Children's Hospitals Graduate Medical Education Payment Program: Past Successes and Future Opportunities for Improvement

Introduction

Maintaining an adequate pediatric workforce is essential to ensuring that children have access to the providers they need. In the late 1990s, the American Board of Pediatrics noted that the number of pediatric residents had seen a decline of more than 13 percent and the Pediatric Education Task Force concluded that the lack of adequate federal funding for graduate medical education (GME) at independent children's hospitals was a significant threat to maintaining an adequate pediatric workforce going forward.[1]

In fact, independent children's hospitals were receiving only half of a percent of the federal funding provided to adult hospitals for GME through Medicare as well as unstable and varying support from Medicaid. In total, this situation created an unnecessary barrier to increasing the availability of pediatricians and pediatric specialists serving children across the country.[2]

To remedy the fact that independent children's hospitals did not receive adequate GME payments through Medicare or Medicaid, Congress created the Children's Hospitals Graduate Medical Education Payment Program (CHGME) in 1999 in order to establish a mechanism for independent children's hospitals to receive federal support to train resident pediatricians and pediatric specialists similar to the GME support provided to adult hospitals.[3] Currently, CHGME is authorized through the end of federal fiscal year (FFY) 2011 with a maximum annual appropriation of $330 million (approximately $268 million has been made available this year).[4]

However, as part of his FFY 2012 Budget, President Obama proposed eliminating CHGME entirely as part of an effort to reduce federal expenditures.[5] The elimination from the President's budget suggests that CHGME reauthorization faces significant challenges this year. This paper concisely outlines the past success of CHGME, illustrates why it is still needed, and offers ideas about how to improve the program while continuing the nation's investment in it.

The Success of CHGME

Since its inception, CHGME has been a success in the following ways:

- **CHGME has increased the number of pediatric residents and pediatric resident specialists training at independent children's hospitals.** From FFY 2001 to FFY 2009, independent children's hospitals saw a 16 percent increase in pediatric residents and an 8 percent increase in pediatric specialist residents. This means that over 4,000 residents focused on providing quality care to children were trained in FFY 2009 at independent children's hospitals across the country.[6] Still the number of providers relative to the population is very low, resulting in a ratio of nearly 1,200 children to each individual general pediatrician.[7]
- **CHGME has met pediatric workforce development needs in geographic regions across the country.** CHGME does not benefit only a single region of the United States

but instead has a broad impact. In FFY 2009, 56 independent children's hospitals located across the country received CHGME funding. While the Midwest and South had the largest number of pediatric and pediatric specialist residents being trained at independent children's hospitals receiving CHGME support, both the West and Northeast also had significant numbers, with no region training less than 20 percent of all residents. Independent children's hospitals in all of these regions provide a range of services to children with some being small community hospitals focused on limited services such as rehabilitative care and others serving as large academic medical centers that serve children with complex illnesses.[8]

- **CHGME has ensured that even children living in states without independent children's hospitals have some access to well-trained pediatricians and pediatric specialists.** CHGME has had a positive and widespread impact on the pediatric workforce. In fact, independent children's hospitals are currently training more than 40 percent of all pediatricians and 43 percent of all pediatric specialists in practice across the country. This is true despite the fact that they comprise less than 1 percent of all hospitals nationally.[9]

CHGME has been an effective program that has contributed to enabling children to have access to the providers they need to see in order to stay healthy.

The Continuing Need for CHGME: Addressing the Shortage of Pediatric Specialists

Since the creation of CHGME in 1999, great progress has been made in increasing the pediatric workforce both in terms of pediatricians and pediatric specialists. However more work remains to be done in terms of increasing the number of pediatric specialists. For example:

- **The current supply of pediatric specialists cannot adequately serve the nation's children.** For 80 million children across the country, there are only 28,000 pediatric specialists. Furthermore, on average across regions, there is one pediatric specialist in most specialties for every 100,000 to 200,000 children.[10]
- **Wait times for children to see pediatric specialists are often significant.** For instance, if children need to see pediatric specialists, they must wait between three weeks and five months to even be seen at an appointment in many specialties. Survey results indicate that pediatricians are themselves concerned about this situation with 68 percent of pediatricians working in rural settings and 49 percent of those working elsewhere reporting that they are dissatisfied with wait times for pediatric specialists.[11]
- **As the existing pediatric specialist workforce ages, many residents are not choosing pediatric specialties as careers.** In 2006, several pediatric specialties had only a small number of residents training in them including adolescent medicine, developmental-behavioral pediatrics, and pediatric rheumatology.[12] Moreover, there have been documented cases of job vacancies persisting for over a year in several pediatric specialties including: developmental-behavioral pediatrics, endocrinology, gastroenterology, pediatric neurology, and pulmonology. All of this is occurring while the average age for a pediatric specialist is over fifty.[13]

The overall point is that, even though CHGME has been successful in making significant workforce improvements that have resulted in many children having access to pediatricians and pediatric specialists, **CHGME must continue to be adequately funded in order to ensure that these gains are not lost and that the resources exist to address the access problem that remains with pediatric specialists**.

Investing in and Improving CHGME

Given its track record of success and the remaining shortage of pediatric specialists, continuing to invest in CHGME makes sense from a policy perspective. This reauthorization presents the opportunity to solidify the program's funding while at the same time improving it to make it better able to address specific pediatric workforce needs and act as a catalyst to achieve broader health policy goals. Some recommendations include:

- **Align pediatric residency positions with a local, state, regional, and national workforce strategy.** Similar to the situation with GME residency programs, there is not a requirement that pediatric residency programs be reflective of local, state, or regional workforce needs. Given this, Congress could require independent children's hospitals to assess workforce needs in their service area. The goal would be to use CHGME to more specifically shape the workforce, requiring residency slots to respond to the needs of a region or locality.[14]

- **Condition the receipt of CHGME funds on establishing or strengthening policies improving access for children with public insurance.** Research has shown that children on Medicaid and the Children's Health Insurance Program (CHIP) are more likely to have preventive care visits and are more likely to receive information about healthy diet and exercise practices than children with private health insurance.[15] However, a recent study on access to outpatient specialty care for children on Medicaid and CHIP found that children with public health insurance are much more likely to be denied specialty care or forced to wait for long periods of time for a specialist appointment than children with private health insurance.[16] Given the disparity in access to specialty care between children with public and private insurance, Congress could require, as a condition of receiving CHGME funding, that independent children hospitals have specific policies in place and implemented (if such policies are not already in force and effective) that specifically facilitate equal access to specialty care for all children, regardless of insurance status.

- **Condition the receipt of CHGME funds on demonstrating a commitment to engage in community benefit activities that assist low-income children and their families.** To further strengthen the commitment of independent children's hospitals to low-income children and their families, Congress could require, as a condition of receiving CHGME funding, that independent children's hospitals engage in specific community benefit activities that address the particular health care needs of low-income children and their families. For example, independent children's hospitals could create targeted financial assistance programs aimed at low-income families with children with significant health care needs.

These policy ideas—and others like them—would make an already effective program even more so by using CHGME funding to leverage changes to the pediatric delivery system that could

magnify the already positive impact of the program on children's access to care. It is important to note as well that GME funding aimed at addressing provider needs for adults (distinct from CHGME) also requires similar policy changes (as outlined in Community Catalyst's *Graduate Medical Education: An Untapped Tool for Primary Care Workforce Expansion*) so that it can better respond to provider workforce needs.

Conclusion

We should continue our investment in the nation's pediatric workforce by reauthorizing and adequately funding CHGME. This reauthorization creates a unique opportunity to ensure that the program continues to receive the funding it requires to continue to meet changing needs of the pediatric workforce while at the same time ensuring that this is done in a more accountable way.

Historically, CHGME has received strong bipartisan support in recognition that of the fact that ensuring that children have access to the providers they need is a priority with widespread and deep support among Congressional leaders. The time has come to continue this tradition of bipartisan support in favor of the health of our children by supporting and strengthening CHGME.

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[1] National Association of Children's Hospitals, *The Children's Hospitals Graduate Medical Education Program: Legislative Background*. (Alexandria, VA: National Association of Children's Hospitals 2011), 1. http://www.childrenshospitals.net/AM/Template.cfm?Section=CHGME&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=56200.

[2] National Association of Children's Hospitals, *Children's Hospitals Graduate Medical Education Program*. (Alexandria, VA: National Association of Children's Hospitals, 2010), 1. http://www.childrenshospitals.net/AM/Template.cfm?Section=CHGME&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=56413.

[3] The process for determining CHGME program payments works in the following way. Eligible freestanding children's hospitals submit an initial application each summer and, using the data from these applications, the payments that each hospital will receive for both direct medical education (DME) and indirect medical education (IME) are determined. Between October and March of each year, audits of resident counts reported are performed before a reconciliation application is submitted that determines the final DME and IME payments. DME funding covers costs such as stipends, salaries, and overhead as well as additional training program expenses. IME funding covers expenditures such as decreased productivity on the part of the staff involved with resident training or additional testing ordered as a result of resident training.

[4] "Historical CHGME Funding," National Association of Children's Hospitals, accessed July 6, 2011, http://www.childrenshospitals.net/AM/Template.cfm?Section=CHGME&CONTENTID=57340&TEMPLATE=/CM/ContentDisplay.cfm.

[5] Lawrence Lindner, "Obama Plan To Cut Pediatric Training Draws Protests," *Kaiser Health News*, June 13, 2011, accessed July 21, 2011, http://www.kaiserhealthnews.org/Stories/2011/June/13/pediatric-residencies-childrens-hospitals.aspx.

[6] "CHGME Program Data," Health Resources and Services Administration, accessed July 6, 2011, http://bhpr.hrsa.gov/grants/childrenshospitalgme/data/gpra.html.

[7] "Frequently Asked Questions," American Academy of Pediatrics, accessed July 25, 2011, http://www.aap.org/workforce/.

[8] Health Resources and Services Administration, *Distribution of the Number FTE Residents in GME programs and CHGME Payments by Census Region*. (Rockville, MD: Health Resources and Services Administration, 2011), 1-2. http://bhpr.hrsa.gov/grants/childrenshospitalgme/data/analyses.html.

[9] National Association of Children's Hospitals, *Children's Hospitals Graduate Medical Education Program*, 1.

[10] American Academy of Pediatrics, *America's Children Need Access to Pediatric Subspecialists*. (Elk Grove Village, IL: American Academy of Pediatrics, 2010), 1. http://www.aap.org/workforce/Sec5203FactSheet.pdf.
[11] Ibid.
[12] Ibid.
[13] Ibid, 2.
[14] Fitzhugh Mullan, *Testimony before the House Energy and Commerce Subcommittee on Health*. (Washington, DC: The George Washington University, 2009), 10. http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_3AD121E5-5056-9D20-3D0CF0B992D212F1.pdf.
[15] Cynthia D. Perry and Genevieve M. Kenney. "Preventive Care for Children in Low-Income Families: How Well Do Medicaid and State Children's Health Insurance Programs Do?," *Pediatrics* 120 (2007): e1393-e1401. http://pediatrics.aappublications.org/content/120/6/e1393.full.pdf+html.
[16] Joanna Bisgaier and Karin V. Rhodes, "Auditing Access to Specialty Care for Children with Public Insurance," *The New England Journal of Medicine* 364 (2011): 2329. http://www.nejm.org/doi/pdf/10.1056/NEJMsa1013285.