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REAUTHORIZATION OF THE CHILDREN'S HOSPITAL GRADUATE MEDICAL EDUCATION PROGRAM

WEDNESDAY, MAY 23, 2018

House of Representatives

Subcommittee on Health

Committee on Energy and Commerce

Washington, D.C.

The subcommittee met, pursuant to call, at 1:00 p.m., in Room 2322 Rayburn House Office Building, Hon. Michael Burgess [chairman of the subcommittee] presiding.

Members present: Representatives Burgess, Guthrie, Upton, Shimkus, Blackburn, Latta, Lance, Bilirakis, Long, Bucshon, Brooks, Mullin, Hudson, Collins, Carter, Green, Schakowsky, Matsui, Schrader, Kennedy, and DeGette. Staff present: Daniel Butler, Staff Assistant; Zachary Dareshori,

Legislative Clerk, Health; Ed Kim, Policy Coordinator, Health; Kristen Shatynski, Professional Staff Member, Health; Jennifer Sherman, Press Secretary; Austin Stonebraker, Press Assistant; Jeff Carroll, Minority Staff Director; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; and Samantha Satchell, Minority Policy Analyst.

Mr. Burgess. We thank all of our guests for being with us today. I call the subcommittee to order. I recognize myself 5 minutes for the purpose of an opening statement as we convene the legislative hearing on H.R. 5385, the reauthorization of the Children's Hospital Graduate Medical Education Program.

This legislation authored by Ranking Member Green and the chairman of this very subcommittee is important in ensuring that we have adequate financial support for our pediatric workforce of the future. Prior to the establishment of Children's Hospitals Graduate Medical Education, the hospitals received minimal education funding because Medicare is the primary funding source for graduate medical education programs and children's hospitals have few Medicare patients.

In 1999, Congress created the Children's Hospitals Graduate Medical Education program as part of the Healthcare Research and Quality Act which authorized funding to directly support medical residency training at children's hospitals for a period of 2 years. This program is especially crucial in training our pediatric subspecialists.

Children's hospitals have a unique patient population

with medical conditions from which pediatric medical residents can learn and develop critical skills. The experience gained from such a residency helps prepare and train physicians for the complex reality of pediatric medicine that they will face in the future of their medical careers. Certainly, as someone who spent his career as an OB/GYN and did his residency at Parkland Hospital, I know that residency programs play a vital role in shaping our nation's physician workforce. Our pediatric workforce of course is no exception.

Before us today are witnesses who will be able to explain to us the substantial role That Children's Hospital Graduate Medical Education plays in the ability of children's hospitals to build a strong pediatric workforce. Currently these hospitals face a workforce shortage which has led patients and their families to suffer through long waiting periods to book even just an initial appointment with pediatric specialists and subspecialists.

According to the Children's Hospital Association, almost half of children's hospitals reported vacancies for child and adolescent psychiatry in addition to developmental pediatrics. The Children's Hospital Association also reports

that pediatric specialists in emergency medicine, physical medicine, rehabilitation, endocrinology, rheumatology, hospitalists, pain management, palliative care, and adolescent medicine are frequently reported as experiencing vacancies longer than 12 months.

The workforce shortage is something that I am concerned about and we are all working to correct. Passing this legislation is an integral part in maintaining and sustaining our workforce. In calendar year 2016, Children's Hospital Graduate Medical Education funding helped to support well over 7,000 residents at 58 hospitals across the country. Our children do deserve the best care available to them and ensuring that we have adequately prepared our pediatric workforce is the first step in providing quality care to our children.

Hospitals that receive this funding train nearly half of our nation's pediatricians and pediatric subspecialists. This bill will authorize $330 million per year in funding for fiscal years 2019 through 2023 for the Children's Hospital Graduate Medical Education program. This is a $30 million per year increase in this funding which has only been appropriated at a level of around 300 million for each of the

past 5 years.

I should say parenthetically I learned something about the President's budget from Children's Graduate Medical Education, it is always zeroed out by the administration whether it is a Democratic or a Republican administration. The Bush administration zeroed it out. The Obama administration zeroed it out, Trump administration, and it is always up to this committee to bring those dollars back.

So that is the happy course that we are embarked upon in partnership today. Texas Children's Hospital, one of the top five children's hospitals in the country is represented today by Dr. Gordon Schutze.

Dr. Schutze, obviously as the chairman and ranking member of the committee, this is a Texas-focused, Texas-centric committee and we want to give you a warm welcome and thank you for being willing to testify before us today.

Dr. Guralnick, thank you to you for providing your time and expertise for us as well.

Texas Children's Hospitals are primarily partners with Baylor College of Medicine which is one of the largest academic pediatric departments in the United States with over 1,300 faculty members. Texas Children's has well over a

thousand people training in hospital GME programs which amounted to over $42 million in costs in 2017 and almost 11 million of that or about 25 percent was covered by Children's Graduate Medical Education.

Similarly, Children's Health System of Texas has just six million of its thirty million in teaching programs covered by Children's Hospital Graduate Medical Education. Needless to say, this program is vital in allowing children's hospitals to maintain and grow their workforce especially as the need for new programs such child and adolescent psychiatry emerges.

I want to thank our witnesses for testifying before us. I look forward to a productive discussion of this important legislation. I would yield to the gentlelady from Tennessee.

[The prepared statement of Mr. Burgess follows:]

**********COMMITTEE INSERT 1**********

Mrs. Blackburn. I thank the chairman for yielding. And I want to say thank you to you all for being here today. When we talk about this program, we talk about it in Tennessee as being something that affects the delivery of medicine. St. Jude is a recipient of funds from this program. We know the good that it does. We want to make certain that there is sufficient accountability and transparency, so I thank the chairman for the hearing and I yield back the balance of my time.

[The prepared statement of Mrs. Blackburn follows:]

**********COMMITTEE INSERT 2**********

Mr. Burgess. The gentlelady yields back and the chair now recognizes Mr. Green, ranking member of the subcommittee, 5 minutes for your opening statement, please.

Mr. Green. Thank you, Mr. Chairman, for holding this legislative hearing on the reauthorization of the Children's Hospital Graduate Medical Education program and for working with me to introduce the Children's Hospital GME support reauthorization, H.R. 5385 earlier this year.

I want to thank our two panelists, Dr. Gordon Schutze, the executive vice chair of the pediatric at Texas Children's Hospital in Houston, and Dr. Sarah Guralnick, associate dean for Graduate Medical Education at the University of California Davis, for joining us today. It has pleased me that we are holding a hearing to reauthorize the payment program that has provided needed funding to train pediatricians since it was first authorized under the Healthcare Research and Quality Act.

Dr. Burgess and I as chair and ranking member of this subcommittee have worked together to develop the legislation to reauthorize this vital program. The program, payment program was created to authorize payments to children's hospital support needed in vital medical residency training

programs. Although most hospitals typically receive GME funding through Medicare, pediatric hospitals treat very few patients enrolled in the Medicare program, denying these hospitals the similar support from the federal government for medical training. This program provides needed funding for training the pediatric workforce including pediatricians, pediatric subspecialists, neonatologists, pediatric psychiatrists, adolescent health specialists as well as other physician types in non-pediatric focused specialties that may rotate through children's hospitals for a period of time during their residency.

Since its creation this payment program has made it possible for thousands of pediatricians to receive training. These physicians training in one of the 58 freestanding children's hospitals throughout 29 states, District of Columbia, and Puerto Rico go on to serve in rural areas and other underserved areas helping to alleviate the pediatric workforce shortage. The program is needed now more than ever to help train the pediatric workforce that will be required to meet the needs of the growing pediatric demographic.

The program fills a vital gap in health care by providing the funding needed to train pediatricians,

pediatric specialists in many hospitals throughout the nation. The physicians train through the program to provide needed pediatric care throughout the United States including the children living in underserved and rural communities. I encourage my colleagues on the subcommittee to support the reauthorization of this vital program in order to help ensure there is enough pediatricians to provide needed healthcare services to our future generations of Americans.

And, Mr. Chairman, you are so right. The President's budget zeroed it out, but like you said previous Presidents did. The beauty of the House of Representatives, thank goodness, is we write our own bills and we write our own appropriations bills so these vital programs can continue to be servicing. And thank you, Mr. Chairman. I yield back the remainder of my time.

[The prepared statement of Mr. Green follows:]

**********COMMITTEE INSERT 3**********

Mr. Green. Anybody want it? Oh, Mr. Chairman, if you don't mind, I would like to yield the remainder of time to my colleague from California.

Mr. Burgess. The gentlelady is recognized.

Ms. Matsui. Thank you very much, Mr. Chairman, and thank you, Mr. Green, for yielding. I thank both of the witnesses here today, Dr. Guralnick and Dr. Schutze, for your testimony. Dr. Guralnick, you are from UC Davis in my district and thank you very much for your work with children and families.

We are here today to discuss the importance of the Children's Hospital Graduate Medical Education program. As you point out, federal investment in medical education is so important because it is very expensive to train doctors and we all benefit from the services that they provide. It is particularly expensive and time-consuming to train those going into specialities. As our pediatricians always say, children are not just small adults, and specialized training is needed to treat children especially those with complex needs.

With growing student loan debt it is getting harder and harder to lure qualified individuals into fields like this so

we need to keep it up. I look forward to hearing from the witnesses about the importance of the Children's Hospital GME program and to work with my colleagues to reauthorize it. Thank you and I yield back to Mr. Green.

[The prepared statement of Ms. Matsui follows:]

**********COMMITTEE INSERT 4**********

Mr. Green. Mr. Chairman, I yield back my time.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. Pending the arrival of the chairman of the full committee, the chair will now recognize the ranking member of the full committee, Mr. Pallone of New Jersey, 5 minutes for an opening statement, please.

Mr. Pallone. Thank you, Mr. Chairman. Every parent understands how stressful it can be when your child gets sick and how important it is to have a trusted provider to turn to in these moments. And that is why it is critical that we continue to invest in the Children's Hospital Graduate Medical Education program.

Over the years, Children's Hospital GME has helped to build a more robust pediatric workforce so that children across the country have access to quality care for the most common to the most severe health conditions. And currently, more than half of pediatric specialists and close to half of all general pediatricians trained are supported by Children's Hospital GME funds. In addition to the training, CHGME funds help to enhance hospitals' research capabilities so that we can develop new cures and treatments for some of the terrible diseases afflicting kids today, and CHGME hospitals also play

an important role in providing care to vulnerable and underserved children.

While this program has helped us reverse declines in our pediatric workforce, we know that some areas of the country still face shortages of pediatric providers, mainly pediatric subspecialists. These shortages severely impact care and lead to longer waits and a time-significant travel for children seeking care. And pediatric specialists care for some of the sickest children in the nation and help them live longer, healthier lives. We need to do all we can to make sure every community has adequate access to these specialized providers.

And CHGME has long been a priority of mine. I was pleased to lead the last reauthorization of the program with former Health Subcommittee chairman Joe Pitts. The last reauthorization made some important changes to the program that have since allowed new hospitals to receive the Children's Hospital GME funds. It also allowed for HRSA to create a quality bonus system for the program and I look forward to the agency's continued implementation of that system.

I want to thank Ranking Member Green and Chairman

Burgess for introducing bipartisan and bicameral legislation to reauthorize this vital program. Their bill, H.R. 5385, would reauthorize the program for another 5 years and allow for the program to support even more residents than it currently does. I am hopeful that we will move this legislation through our committee in the near future so that we can provide certainty to hospitals that are doing this much needed training. And with that I want to thank the witnesses and look forward to your testimony.

I don't know if anybody else wants my time. I will yield to the gentlewoman from Illinois.

[The prepared statement of Mr. Pallone follows:]

**********COMMITTEE INSERT 5**********

Ms. Schakowsky. I thank the gentleman for yielding. I just wanted to say how pleased I am that we are here considering this bipartisan legislation. I am proud to be a co-sponsor of H.R. 5385, the Children's Hospital GME Support Reauthorization Act. We must ensure that we have a strong health workforce because it is the backbone of our healthcare system. Whether it is bolstering the pediatric workforce as we are doing today or building our geriatric workforce as we do in H.R. 3713, which is also a bipartisan geriatric workforce and caregiver enhancement act I introduced along with Representative Doris Matsui and Representative McKinley, it is critical that we have the necessary medical infrastructure. It is clear that the Children's Hospital GME programs have been incredibly effective.

And I yield back unless someone else wants your time. Okay, thank you.

[The prepared statement of Ms. Schakowsky follows:]

**********COMMITTEE INSERT 6**********

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. The chair will hold the time for the chairman of the full committee pending his arrival, but otherwise we will conclude with member opening statements. And the chair would like to remind members that pursuant to committee rules all members' opening statements will be made part of the record.

And we do want to thank our witnesses for being here today and taking the time to testify with us before the subcommittee. Each witness will have an opportunity to give an opening statement and this then will be followed by questions from members.

Our first panel today, or our only panel today, we will hear from Dr. Gordon Schutze, professor of pediatrics at Baylor College of Medicine, the executive vice president and chief medical officer of Baylor International Pediatric AIDS Initiative at Texas Children's Hospital; and, Dr. Susan Guralnick, associate dean for Graduate Medical Education, University of California at Davis. Again we appreciate you being here with us today.

Dr. Schutze, you are recognized for 5 minutes for your opening statement, please.

STATEMENTS OF GORDON E. SCHUTZE, M.D., PROFESSOR OF PEDIATRICS, EXECUTIVE VICE PRESIDENT AND CHIEF MEDICAL OFFICER, BAYLOR INTERNATIONAL PEDIATRIC AIDS INITIATIVE, TEXAS CHILDREN'S HOSPITAL; AND, SUSAN GURALNICK, M.D., ASSOCIATE DEAN FOR GRADUATE MEDICAL EDUCATION, UNIVERSITY OF CALIFORNIA, DAVIS

STATEMENT OF GORDON SCHUTZE

Dr. Schutze. Chairman Burgess, Ranking Member Green, and members --

Mr. Burgess. This is the premier technology committee of the United States House of Representatives.

Dr. Schutze. All right.

Mr. Burgess. Thank you. Very good.

Dr. Schutze. Chairman Burgess, Ranking Member Green, and members of the subcommittee, thank you for the opportunity to testify in support of H.R. 5385. I am Dr. Gordon Schutze. I currently serve as executive vice chair of the Department of Pediatrics at the Baylor College of Medicine at Texas Children's Hospital in Houston, Texas.

I appreciate the opportunity to come before you to represent Texas Children's Hospital and the 220 other members

of the Children's Hospital Association, all of whom support this important legislation that is critical to the future of children's health in our nation. First, I want to thank the subcommittee for your historic support of this program, especially our Texas members, Chairman Burgess and Ranking Member Green, for introducing this bipartisan legislation to reauthorize and strengthen the support for CHGME, a vital program to our nation's children's hospitals.

I graduated from the Texas Tech School of Medicine. I did my residency training in pediatrics followed by subspecialty training in infectious disease at Baylor College of Medicine and Texas Children's Hospital. I currently manage the growth and direction of our graduate medical education training programs, and with this in mind I am pleased to be here with you this afternoon to provide you with the insight on this importance of CHGME.

Baylor's Department of Pediatrics is the largest department of pediatrics in the United States with over 1,300 faculty members, all of whom are on staff at Texas Children's Hospital. Along with voluntary faculty from the community, these faculty and staff train over 1,100 residents and fellows at our hospital, making it the largest pediatric

residency training program in the country.

GME learners rotate through affiliated hospitals and programs in Houston and around the world. Of the residents that work for us, 410 are recognized CHGME slots of which 216 are residents in training and the remaining 194 are considered fellows or subspecialty residents. Of these, only 165 are eligible for CHGME funding per rules which limits the number of new physicians our program can consider for funding.

Having one of the largest training programs also results in significant expense. Our CHGME costs for the program for 2017 amounted to $42.7 million of which $10.9 million were funded through CHGME support. Thus, only about 25 percent of our program costs are covered by CHGME dollars. The remaining expenses are paid by Texas Children's Hospital. Besides the financial commitment, children's hospitals also have to guarantee funds for the entirety of a resident's training over 3 years or more, train our post-graduate learners on issues surrounding patient safety, and most importantly, children's hospitals are committed to diversity in the workforce. We recruit and train doctors that look and sound like the patients and families that we serve.

Children's hospitals serve as a majority safety net provider with more than half of their care devoted to children in the Medicaid and CHIP programs. Through what I think is an innovative program called Project DOC, providers are sent to the homes of children with complex medical conditions to learn from their parents what it is like to care for chronically ill or a medically complex child.

In pediatrics, unlike in adult residency programs, residents and fellows are trained early on that they will be serving no less than two people when caring for a child, meaning they must be taught how to communicate with the patient and his or her caregiver not only in how they assess a patient's medical history, but also how they will conduct the exams, easing the anxiety of the child as well as the family unit. Because children's hospitals see the sickest of the sick, our training programs train pediatric specialists in complex care and behavioral health creating pediatricians who have an expertise in both of these emerging health issues.

The children's hospitals of this nation serve as a center for scientific discovery focused solely on kids. They provide lifesaving clinical research that is a direct result

of their strong academic programs which are inextricably tied to support by CHGME. CHA data provides support for a strong correlation between physician shortages and access to pediatric care for America's children.

Nationally, workforce shortages exist in critical subspecialties as mentioned here earlier such as pediatric neurology, developmental and behavioral pediatrics, child and adolescent psychiatry, and others. Meanwhile, as the national population of children continues to grow so does the growth of children with chronic and complex medical conditions. It is essential that we work to continue to train this workforce and seek to attract physicians to these areas of high need. CHGME support will help us continue to address these workforce gaps and increase access to vital specialized services.

In closing, CHGME is a sound investment in the future of our nation's children. CHGME helps to ensure a stable future for our nation's children's hospitals and its pediatric workforce. I respectfully ask for your support of H.R. 5385 and the requested funding of $330 million. Thank you for this opportunity to share my professional insight. I respectfully ask that my written testimony be submitted for

the record, and I am happy to answer any questions at this time.

[The prepared statement of Dr. Schutze follows:]

**********INSERT 1**********

Mr. Burgess. Thank you, Dr. Schutze, and your written statement of course will be part of the record.

Dr. Guralnick, you are recognized for 5 minutes for an opening statement, please.

STATEMENT OF SARAH GURALNICK

Dr. Guralnick. Chairman Burgess, Ranking Member Green, and members of the subcommittee, thank you for holding this hearing on legislation that is critical to the training of the next generation of providers of medical care to children. My name is Dr. Susan Guralnick and I am a pediatrician with over 30 years in clinical practice. I am currently the associate dean for Graduate Medical Education at UC Davis Health, but I am here today in an official capacity representing the American Academy of Pediatrics, AAP, and its committee on pediatric education which I chair.

The AAP is a nonprofit professional organization of over 66,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists. The American Academy of Pediatrics strongly supports H.R. 5385, the Children's Hospital GME Support Reauthorization Act of 2018. We particularly want to thank Chairman Burgess and Ranking Member

Green for sponsoring this important legislation.

Children are not just little adults. They require medical care that is appropriate for their unique needs. Pediatricians, a term that includes primary pediatricians, pediatric medical subspecialists, and pediatric surgical specialists are physicians who are concerned primarily with the health, welfare, and development of children and are uniquely qualified to care for children by virtue of this interest and their initial training.

Training to become a pediatrician generally includes 4 years of medical school followed by residency training of at least 3 years of hands-on intensive graduate medical education or GME training devoted solely to all aspects of medical care for children, adolescents, and young adults. All told, training to become a primary care pediatrician consists of approximately 12- to 14,000 clinical hours.

After residency, pediatricians may elect to complete fellowship training of usually at least another 3 years to become a pediatric medical subspecialist. The training required of a pediatric medical subspecialist prepares them to take care of children with serious diseases and other specialized healthcare needs. Examples include neonatologists who take care

of babies born experiencing withdrawal from in utero opioid exposure, pediatric endocrinologists who address child obesity and diabetes, and pediatric oncologists who treat children with brain cancer. When children require surgery, specialized pediatric surgeons offer specialized surgical skills for children. Pediatric surgical specialists begin their medical training in general surgery but must also complete fellowship training in their desired pediatric surgical specialty.

Safe and high quality care of children requires specialized training. In addition to a general knowledge of diseases, pediatric specialists must know and understand the various ways that diseases present and are managed with consideration of the age of the child. As children grow, their risk of each illness changes as does its management. The pediatric specialist must continuously monitor and address each child's growth, development, and behavior. Pediatric specialists also must be trained in appropriate interaction and shared decisionmaking with parents.

As a result of advances in medical care, the United States has greatly increased the survival of children. These children require specialist physicians with expertise in complex and specialty care to meet their needs. Training physicians to

provide optimal health care for children requires substantial investments of time, effort, and resources. The federal government investment in medical training is essential in making this happen. GME funding benefits everyone. It is a costly endeavor but it is essential to ensuring that America's physicians are trained and in sufficient supply to be able to tackle the complicated health challenges we face as a nation.

While Medicare is the largest source of GME funding, the Children's Hospital Graduate Medical Education, CHGME, program is an essential funding component for hospitals that do not receive Medicare GME support. In fact, hospitals that receive CHGME funding train approximately half of all primary care and subspecialty pediatricians in the United States, making the program indispensable for maintaining the pipeline of physicians trained to take care of children.

At my institution the hospital receives Medicare GME because we are integrated into an adult system that receives this funding which helps finance our pediatric training programs as well. However, freestanding children's hospitals without such institutional affiliations do not qualify for this Medicare funding. Prior to the CHGME program these hospitals were unable to directly utilize federal GME funding. CHGME is therefore an

essential tool in continuing to address the inequities in training funding for hospitals solely focused on the care of children.

Pediatrics is facing a significant shortage of medical and surgical subspecialists. We are not training enough subspecialists to keep up with the increasing needs among children especially those with special healthcare needs. Unfortunately, these shortages impact patient care. Wait times to see pediatric subspecialists are unacceptably high among many specialties and families often need to travel long distances, many times to another state to see the appropriate specialists. Simply put, children should not have to get on an airplane to see their doctor.

Renewing CHGME is a first step, but training funding alone will not sufficiently address these shortages. There are also personal financial drivers including high student debt load that make pediatricians think twice before deciding to further specialize. We must address these negative incentives. We also urge this committee to look seriously at legislation that would offer loan repayment for pediatric subspecialists.

Thank you for the opportunity to share our thoughts with you today and I welcome any questions you have.

[The prepared statement of Dr. Guralnick follows:]

**********INSERT 2**********

Mr. Burgess. Thank you, Dr. Guralnick. We appreciate both of you being here today. We will move to the question portion of the hearing. We will have a series of votes in probably 15 or 20 minutes. For that reason I am going to go down the dais and recognize Billy Long from Missouri, 5 minutes for questions, please.

Mr. Upton. Will the gentleman yield just for a second while he gets his thoughts together?

Mr. Long. Sure.

Mr. Upton. You know, I just want to say we really appreciate you being here. I was on the super committee. It was a bipartisan, bicameral committee a few years ago and there was a serious effort to go after GME, not only after kids, but the whole program. And you will be pleased to know that Rob Portman and Dave Camp and I were the ones that really put the skids to that.

I visited Texas a number of times. I have seen the work. I have great schools in Michigan as well, but all around the country we travel and get testimony from you folks. I had a number of physician, related fields, in my office yesterday and again this week a number of different times. We just really appreciate your testimony. This is an important bill that we

need to move forward. And particularly now that we have a budget agreement, something that the President signed with bipartisan support in both the House and the Senate, I have got to believe that we aren't going to be worried with threats coming after GME.

So I have a new medical school in my district, Kalamazoo, Western Michigan University. I was there on Saturday for a huge event. This is critical if we are going to train the folks to be back. I just want to say thanks, and I yield to my good friend, Mr. Long.

Mr. Long. Thank you. And as a parent of a newly minted pediatrician I appreciate you all being here today. My daughter finishes up June 30th her third-year residency and will start practicing very shortly after that.

Dr. Guralnick, in your testimony you focus on the shortages in pediatric subspecialty care. Could you discuss how the shortages are impacting patient care?

Dr. Guralnick. Thank you for that question. There is a significant impact in many areas. One of the difficulties is having the funding to encourage people to do these specialities, to take the time. They often don't have enough, it affects their earnings to choose to do these specialties, and without

enough specialists -- we have states that don't have, or have one subspecialist in any particular area. There are lots of parts of the country where people have to go hundreds of miles to reach somebody.

And say, for example, you have a child with diabetes or you have a child with epilepsy. They can't necessarily access specialists in their area to take appropriate care of them.

Mr. Long. You mentioned or you noted in your testimony and mentioned here that pediatricians face negative incentives to further specialize in care. Could you expand on what these issues are and how they disincentivize pediatricians from further specialization?

Dr. Guralnick. One of the interesting things to me is that there is, it is counter intuitive in that generally a subspecialist would earn a higher salary than a generalist. But the money that they lose over the time that they train to become a subspecialist when they could have been in primary care practice ends up costing them more than it gains them to become a subspecialist. Also over that time they gain interest in many of the loans that they have been building up so that they go further into debt over the years that they are subspecialty training.

Mr. Long. I am the sponsor of the Ensuring Children's Access to Specialty Care Act which would allow pediatric subspecialists practicing in underserved areas to participate in the National Health Service Corps loan repayment program. Could you discuss the importance of loan repayment programs in addressing the shortages of these pediatric subspecialists?

Dr. Guralnick. Yes, thank you for your leadership on that issue. That is a very important issue. Right now the National Health Service Corps is very helpful in getting primary care doctors into underserved areas, but because subspecialists cannot get the loan help with that with the loan repayment we don't get the people going into subspecialties who need to get that loan repayment through that service, as well as if we have people who are subspecialists placed in those underserved areas it greatly impacts the care of children in areas where we have no subspecialists at this time.

Mr. Long. And what else can we do to address these negative incentives to narrow that gap in these subspecialties?

Dr. Guralnick. Well, one of them is the incentives for the trainees, as I mentioned. One of the other negative incentives is for hospitals because fellowships right now through funding only get 50 percent of what residents receive to get their

training. So hospitals are disincentivized to have many fellows there because they have to pay a great portion of the salary and support of those trainees.

Mr. Long. Okay, thank you.

And Dr. Schutze, in your testimony you talk about how the number of children with complex medical conditions is growing at a faster rate than the overall child population, but workforce shortages persist more acutely among pediatrician subspecialties. How can we address these workforce gaps and increase access to these vital specialized services?

Dr. Schutze. I think giving exposure to residents and learners early on about complex medical issues and how to take care of them. I think general pediatricians as a rule sometimes don't get exposed to many of these and I think the more exposure they have in training, the more comfortable they are with them, the more comfortable they will be taking care of these people and these kids when they get out.

Also that will help because of the shortages in some subspecialties if we can make the general pediatrician more comfortable with these complex patients then there will be less of a need to require total subspecialty care by these patients.

Mr. Long. Okay.

Dr. Schutze. It is a win-win for everybody.

Mr. Bucshon. Can you give me your 20 seconds?

Mr. Long. I yield 22 seconds.

Mr. Burgess. The chair rejoices. The chair thanks the gentleman.

Mr. Bucshon. He yielded 20 seconds to me.

Mr. Burgess. Oh, oh. He yielded to you. Oh my gosh.

Mr. Bucshon. I will be brief.

Mr. Long. Actually he grabbed my microphone.

Mr. Bucshon. I did, yes. I was a heart surgeon before I was in Congress and I just want to say this. The debt that kids are coming out of medical school I firmly believe is impacting their career choices and, historically, as you know pediatricians have been on the lower end of the salary scale of medical specialists. And I am being presumptuous here, but I am just making the assessment that it likely is impacting the ability to recruit pediatricians as well as pediatric subspecialists. I yield back to Billy Long.

Mr. Long. And I yield back to the chairman. Thank you all again very much. I appreciate what you do and your dedication and you all being here today. Thank you.

Mr. Burgess. The chair thanks the gentleman. The

gentleman yields back. The chair recognizes the gentleman from Texas, Mr. Green, 5 minutes for your questions, please.

Mr. Green. Thank you, Mr. Chairman. It is nice to have a fellow from Missouri say you all.

Dr. Schutze, you mentioned in your testimony that your department is one of the largest academic pediatric departments in the country and Texas Children's Hospital has made significant investment in graduate medical education. First of all, I would like to thank you. A lot of my district is medically underserved in a very urban area and Texas Children's Hospital has clinics in those areas where a lot of our other hospitals do not, so I sure appreciate it. Could you discuss how much of your department's pediatric training is funded through the federal GME programs? Is CHGME the largest source of support for Texas Children's pediatric training programs?

Dr. Schutze. Yes, thank you, Congressman Green. It is the only source of funding we have outside of Texas Children's itself. So the hospital itself ponies up the rest of the money, otherwise that is the only source of funding outside of the hospital that we have.

Mr. Green. You note in your testimony there is a pediatric workforce shortfall nationwide, especially in pediatric

subspecialties such as developmental pediatrics, children and adolescent psychiatry, and pediatric genetics. What are the underlying reasons dissuading doctors from specializing in pediatrics?

Dr. Schutze. Much like what Dr. Guralnick said, some of it is financially based, you know, some of these subspecialties get paid less than general pediatricians plus the time put in. Some of it is just it takes the right person to do some of these specialties. And I think in order to have people go into these specialties they have to be exposed to these specialties at a young age.

Many of the smaller pediatric programs don't have a behavioralist or an adolescent psychiatrist, et cetera, and so the larger programs, really, it becomes incumbent upon us to get exposure to young learners early so that they can be exposed to these specialties and hopefully pick these specialties to go into.

Mr. Green. How does CHGME help address that challenge? Obviously, it is your only funding.

Dr. Schutze. Right. It is our only funding, but it gives us the ability to bring in residents of all sorts so they can get this type of training. It is essential to what we do.

Mr. Green. Will the $30 million increase in annual funding set in H.R. 5385, the Children's Hospital GME Support Reauthorization Act, help address this challenge?

Dr. Schutze. Absolutely. I think it will help address those challenges in institutions that already get CHGME funding and maybe it will allow others that don't have access to it to have access to some as well.

Mr. Green. Dr. Guralnick, is this also the only funding for the training at UC Davis, similar to the Texas Children's?

Dr. Guralnick. No, it is not. We are not a children's, a freestanding children's hospital so we get Medicare GME at our institution.

Mr. Green. That was my question about how important is CHGME to freestanding hospitals operating graduate medical programs. If that didn't exist would these programs adequately support the GME at these hospitals?

Dr. Guralnick. Without that I think there would be institutions that could not support GME at all. They would not be able to have the funding to support those programs and certainly a lot of the programs would close.

Mr. Green. Okay.

Thank you, Mr. Chairman, and I will yield back my time.

Mr. Burgess. The chair thanks the gentleman. We do have a series of votes on the floor so we are going to briefly recess the subcommittee and we will reconvene immediately following the votes on the floor. The subcommittee stands in recess.

[Whereupon, at 1:38 p.m., the subcommittee recessed, to reconvene at 2:35 p.m., the same day.]

Mr. Burgess. I will call the subcommittee back to order and recognize myself for 5 minutes for questions. And to the ranking member since we have a Texas contingent here today that is pretty solid, Dr. Benjy Brooks was the first woman to become a pediatric surgeon in Texas. She was actually at the Texas Medical Center when I was in medical school down there many years ago. She was actually born in the town that I practiced in, Lewisville, Texas, and interestingly enough she was born in 1918, so this is her centennial year.

The reason I bring up her name is because we have had so many people today say that children are not just little adults, fair statement. Benjy had kind of a unique way, or Dr. Brooks had a unique way of phrasing it. She would get right in your face and say, kids are different. So kids are different and I will take her admonition now these many years later as we work this.

I think one of the things, Dr. Schutze and Dr. Guralnick, one of the things that I have worked on for a number of years has been physician workforce. Not just in the pediatric space but in a larger perspective. But talk to us a little bit about the availability of residency slots for people who are graduating medical school. How are we doing on that?

I will start with you, Dr. Schutze, in the state of Texas, and then we are interested in California as well.

Dr. Schutze. That is an interesting question. Thank you for the question. You know, as medical schools are increasing to try to increase output of physicians, and certainly even in Texas we now have, you know, a school in Austin, a school in Valley, you know, U of H may be getting a school soon, TCU, Incarnate Word, et cetera. And so what is happening is that we are going to certainly produce more physicians in the state and in the nation, but again the number of GME slots hasn't expanded.

And so, for instance, it used to be that we may see ten percent of pediatric trainees coming in may have been from foreign medical schools, now that number continues to shrink and at some point in the next decade we will probably exceed number of GME spots versus the number of graduates we have getting out

of medical school.

Mr. Burgess. And, Dr. Guralnick, for California?

Dr. Guralnick. Yes, and I agree with everything Dr. Schutze just said. I guess the other important piece is that we aren't necessarily have, I guess, incentivizing people to go into the specialties in the areas that we need. And when we do increase if we get to GME slots it would be helpful to have some way of incentivizing or encouraging those to be in areas that are underserved and in specialties that are underserved.

Mr. Burgess. And you of course are talking too about the opportunity costs that are lost with additional time in training in a subspecialty, that although it may pay more than the generalist pediatrician it may not be enough to offset the cost of the opportunity cost of going through that additional training. So typically someone finishes up almost 4 years of medical school, well, actually it was 3 years when I went. I was the 3-year wonder kid across the street from Baylor.

But 4 years of medical school, 3 years of general pediatric residency, so now you are 7 years after graduating from college for a subspecialty. To be a pediatric cardiologist how long, additionally, are we talking about in investment?

Dr. Guralnick. A minimum of 3 additional years without any

further subspecialization.

Mr. Burgess. So there is even further subspecialization in the field of pediatric cardiology?

Dr. Guralnick. There can be.

Mr. Burgess. To valvular disease, vessel disease and that sort of subspecialization?

Dr. Guralnick. There -- yes.

Dr. Schutze. At our institution we have fourth year fellowships in heart failure or cardiac imaging or electrophysiology, those kind of things. And like in HemOnc we now have a fourth year of fellowship in leukemia or lymphoma, or brain tumor, et cetera. So they are adding --

Dr. Guralnick. Congenital heart disease.

Dr. Schutze. Yes. They are adding these things over and over and over.

Mr. Burgess. So it is again working on workforce issues over the past several years in Texas we have been focused on the fact that we are educating more doctors that we can perhaps provide residency slots for, and as you mentioned, Dr. Schutze, that problem may even be becoming a little more acute. The concern then is that from a physician standpoint we tend to practice where we put down roots which is typically where we do

our residency program.

So referral patterns get established, the comfort with the doctors that are also in the community, we frequently will find our significant other and marry at the time of residency, so all of those roots get put down. I can remember when we were dealing with the emigration of doctors after Hurricane Katrina and of course Dallas-Fort Worth area was probably as guilty as any from trying to attract the doctors from Charity to come up to the Metroflex and not put up with hurricanes in the future.

And I remember being struck when we were down there for a field hearing that it was going to be difficult to hold the physician workforce in town and if you didn't -- it is not so much that you were from the area, but your spouse needed to be from the New Orleans area if you were really likely to stay because just the burden of practice became so difficult under those conditions.

Well, obviously Mr. Green and I are focused on this as an issue. We expect to get this into a markup in the subcommittee and then the full committee and we will see what happens from there. I see we are joined by the gentleman from Georgia.

And I recognized you, correct?

Mr. Green. You have, but I will take some more time if you

will give it to me.

Mr. Burgess. I will do that after we recognize Mr. Carter. Oh, oh. I beg your pardon. I didn't see way down in the front row. I don't see as well as I used to. Let me yield 5 minutes to Ms. DeGette for questions.

Ms. DeGette. Thank you, Mr. Chairman. I feel like I am at the kids' table down here.

Mr. Carter. You will get used to it.

Ms. DeGette. But I am really happy --

[Laughter.]

Ms. DeGette. But I am happy I was able to come back because this is a really important issue and GME is really, really important. I want to thank both of you for being with us here today.

As you both may know, Congressman Tom Reed from New York and I co-chair the Congressional Diabetes Caucus. As you mentioned in your testimony, Dr. Guralnick, there is already a shortage in the primary care pediatric subspecialties and that includes pediatric endocrinologists. I was wondering if you could talk about how existing and future shortages of pediatric subspecialists who treat chronic conditions like diabetes can impact diabetes management, quality of life, and eventually life

expectancy.

Dr. Guralnick. Certainly. It is very significant, especially children who have type 1 diabetes, which is more common in children, and then now we have so much more type 2 diabetes from obesity. It is a growing epidemic. There are a lot of complications of diabetes, you know, you can go blind. You can have kidney disease. So it has significant long-term impact on, you know, chronic health, chronic illness, and decreases longevity. And if we don't have subspecialists trained in taking care of these children then we are much more likely to have these complications unrecognized, untreated, with long-term adult negative impact.

Ms. DeGette. And I agree with you. And, you know, my daughter is a type 1 diabetic, and working with her pediatric endocrinologist she would tell me with the type 2 issues in particular they would have kids referred to them at the Barbara Davis Center in Denver. And the regular pediatricians could not diagnose between type 1 and type 2 and children which used to be, as you point out, quite rare but with increasing obesity and lifestyle issues, and the way you treat these two types of diabetes can really make a difference either in life expectancy or complications.

Can you tell me how the CHGME program could actually help to train additional pediatric subspecialists?

Dr. Guralnick. Well, the funding is incredibly important to support people going into the specialty and to support institutions having fellowships for that specialty. There is such a great need nowadays for these numbers of people and we would like to get training in fellowships in various areas. As was mentioned by the chairman the people tend to go often, tend to stay often where they train and so if we can train people in more areas we are more likely to serve more areas with these endocrinologists.

Ms. DeGette. And I agree with that.

Dr. Schutze, you said in your testimony only one percent of the hospitals in the country are eligible to receive CHGME. In Colorado, Children's Hospital in Aurora got just over $6 million in these funds. But even though these hospitals, it is only one percent of the hospitals they are training almost half of the pediatricians including the pediatric psychiatrists and other mental health specialists. I am wondering if you can talk about how CHGME supports children's behavioral health needs.

Dr. Schutze. Sure. That is a great question. You know, as the country goes on and we have gotten better in preventing

infectious diseases, chronic diseases have become the number one issue among kids and adults. And certainly within that behavioral and psychiatric and developmental issues become very important. They are probably the number one chronic disease that we see.

So we approach this from a number of different angles. There are training programs in behavioral and developmental pediatrics that go on that CHGME supports. There is training in neurodevelopmental disabilities that CHGME funds support. And there is training in pediatric psychiatry as well so that we are hitting this from a couple different angles.

Ms. DeGette. Thanks. I just have one last question for both of you. The good news is we are talking about reauthorizing this. But last year because of the difficulties that we had, we had a number of short-term continuing resolutions and in fact the Community Health Center program in CHIP expired. I am wondering if you can both talk very briefly about the importance of having a level and dependable reauthorization is for this program.

Doctor?

Dr. Guralnick. Certainly from my role I am in charge of all of the residency programs in my institution, and so when we

authorize programs to have certain numbers of residents we need to know that the funding will be there. And if the funding is not consistent it is very difficult to say to a program, well, you can have this number of residents every year, because if CGHME is not available then the institution has to provide that funding.

Ms. DeGette. You have to plan that ahead, right?

Dr. Guralnick. You need to plan that. And the training is several years long and so you need to know that the funding will continue to be there throughout their training and for the next people that you accept into the program.

Ms. DeGette. I am out of time, but do you agree with that, Doctor?

Dr. Schutze. I do. And I will just say, for instance, you know, this summer we will have to decide how many positions we have because interviews start in the fall and so we have to know now. And so that inconsistent funding makes it impossible to guarantee you have positions and so you wouldn't advertise them, you wouldn't fill them.

Ms. DeGette. Thank you.

Dr. Schutze. Thank you.

Ms. DeGette. Thank you very much, Mr. Chairman.

Mr. Burgess. The chair thanks the gentlelady. So the 10-year funding for state Children's Health Insurance Program that passed this Congress earlier this year, that was okay? You all were okay with that?

Dr. Schutze. Yes, sir.

Mr. Burgess. All right, just checking.

The gentleman from Georgia is recognized for 5 minutes for questions, please.

Mr. Carter. Thank you, Mr. Chairman, and thank both of you for being here. I really do appreciate it. And, Mr. Chairman, I want to thank you and the ranking member for introducing this reauthorization. It is critical, particularly to us in the state of Georgia. I served in Georgia state legislature on the Health and Human Services Committee and I am well aware of the shortages that we struggle with in the state of Georgia, particularly with physicians, particularly with pediatricians.

Right now in the state of Georgia we have 130 out of the 159 counties that we have in the state, 130 of them are considered healthcare professional shortage areas. And, in fact, out of the 159 counties that we have in the state of Georgia, 61 don't even have a pediatrician. Sixty one counties in the state of Georgia do not have a single pediatrician. Now,

and a lot of those counties are in my district and a lot of them are in south Georgia because of the rural area there.

So it is really a challenge and that is why this legislation is so important. That is why I am a co-sponsor on it and why I appreciate it so much. You know, the Georgia Board for Physician Workforce estimated that the population of Georgia between the years of 2000 and 2015 increased by 24 percent, yet we only increased the number of physicians by 9.4 percent. So obviously we are losing ground there and one of the things that we really struggle with is the residencies and that is one of the things that I wanted to ask you about. What can we do -- I know that states like Georgia and Texas because of the formula that is in place we are not getting the number of residents that we need because it hasn't been updated in awhile. Do you care to comment on that, Dr. Guralnick?

Dr. Guralnick. From our standpoint, from the academy standpoint, and from the GME standpoint, nationally we are really struggling with the caps that were put in place so many years ago.

Mr. Carter. They were put in place when, 1996?

Dr. Guralnick. Yes, whatever number you had at that point.

Mr. Carter. And they haven't updated since then?

Dr. Guralnick. Correct, even though there is many more medical students and populations have increased so drastically. And the level of care fortunately since there is so much more in children's survivorship, we have many, many children with a great many needs, especially special healthcare needs that we are not having enough physicians, enough pediatricians to care for them.

Mr. Carter. Right. That is, you know, I assume it is a responsibility and I am assuming, here, this is a responsibility of the agency to update that formula. Or is it a responsibility of Congress, do either of you know? I don't either, Mr. Chairman. I would ask --

Dr. Schutze. I am not aware.

Mr. Burgess. It actually was changed during the passage of the Affordable Care Act but I can't tell you the precise numbers. It is something we have under active surveillance on the subcommittee level.

Mr. Carter. Okay. Well, I apologize. I am just not educated in who had responsibility of that.

What do you think would be the best way for us to bring the slot allocation up to date without harming other states? Is there a way we could do that without really causing any pain to

other states? Yes, increase funding, right, all across the board.

Dr. Guralnick. Increase funding, yes.

Mr. Carter. Yes, I stepped right in the middle of that I know.

[Laughter.]

Dr. Guralnick. Because you can't damage other people.

Mr. Carter. Never mind. Strike that last question.

I want to talk specifically about in Georgia again, that is what I represent. And the Children's Healthcare of Atlanta, it is the largest pediatric residency training center that we have and because of the CHGME funding they are able to train more than 600 residents and fellows each year and the majority come from state schools. So the majority of them stay. I mean we knew that. We found that out during the time I was serving on the legislature. If you can get them to do their residency in the state usually they will stay. That is why it so important. And we actually funded in the state of Georgia a number of residency, a number of slots for that specific purpose to increase the number of physicians.

But I just wanted to ask you, are there certain challenges to a children's hospital in particular whenever you have this in

place? Are there certain challenges that maybe you don't find in other areas, if it is just specifically for a children's hospital?

Dr. Schutze. If I understand your correction correctly, in order to get people to do training with kids they have to want to deal with kids and not everybody wants to. So you are starting with this specific personality I think that want to do that. Getting them to come, I agree with you a hundred percent. If you want to, you know, get more pediatricians for Georgia, the best way to do it is to get people in pediatrics from Georgia and they are likely to stay there. But, you know, it is also a maldistribution of people within Georgia, you know, because they are going to stay in Atlanta and not go to the other parts.

Mr. Carter. Absolutely. That is why the 61 are mainly in south Georgia.

Dr. Schutze. Right and so that becomes difficult then as well. You know, I recruit pediatricians for our clinics in Africa and I used to work in Arkansas. It is a lot easier to get people to go to Africa to work than it is to go to the Mississippi River Delta. And somehow it is, you know, an adventure when you go to Africa and not so much when you go to

the Mississippi River Delta, but people there are just as poor as the people we treat in Africa, et cetera.

So this maldistribution is something that we need to address as educators and healthcare providers as well. And maybe it requires incentives to get people to go to those places as well, loan repayment, other kind of thing.

Mr. Carter. I know I am way over my time. Just what are your suggestions? How can we improve this situation?

Dr. Guralnick. As you said, the loan repayment is a huge incentive especially with the incredible debt that everybody has nowadays. That is probably the most straightforward way to do it.

Dr. Schutze. Right.

Mr. Burgess. Very well.

Mr. Carter. Good. And I yield back. Thank you, Mr. Chairman.

Mr. Burgess. The gentleman's time has expired. The chair would recognize the gentleman from Texas for a follow-up question.

Mr. Green. Thank you, Mr. Chairman.

By supporting the children's health GME we are supporting the training of quality pediatric providers that help children

not only in the United States but in some cases globally. Dr. Schutze, I understand you are quite involved in the work that Texas Children's Hospital does globally. Could you discuss how the Texas Children's Hospital shares its expertise with our global partners to help children around the world have greater access to specialized care?

Dr. Schutze. Sure. So we have a global health residency where we, actually a pediatric residency of 3 years. We have five slots that we take every year for a 4-year program where we send residents to work in one of our clinics in Africa and Botswana, Malawi, Lesotho, Swaziland, or Uganda for a year to learn about taking care of kids living in resource-limited areas, et cetera. About half of those kids come back and then do further training and some continue to do international work.

But then some stay in our country to work with people living in resource-limited areas like at the FQHCs like in the inner cities, et cetera, et cetera. So I think that year of working globally also really helps them come back to work with populations in resource-limited areas in our own country and our own state and our own city.

Mr. Green. Thank you. And I appreciate, because that is a partnership in Africa with Baylor and --

Dr. Schutze. Correct.

Mr. Green. -- Texas Children's, so thank you. And I don't mind them coming home to service in my FQHCs.

Mr. Chairman, I yield back.

Mr. Burgess. The gentleman yields back. Seeing that there are no further members wishing to ask questions, I again want to thank our witnesses for taking time to be here today. I do have the following documents to submit for the record: a letter from the American Academy of Pediatrics; a letter from the Children's Hospital Association; and a letter from Healthcare Leadership Council.

[The information follows:]

**********COMMITTEE INSERT 7**********

Mr. Burgess. Pursuant to committee rules, I remind members that they have 10 business days to submit additional questions for the record and I ask the witnesses to submit those responses within 10 business days on the receipt of those questions. So, without objection, the subcommittee then is adjourned.

[Whereupon, at 2:56 p.m., the subcommittee was adjourned.]