

Testimony of

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Before the

Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives

**“Reauthorization of the Children’s Hospital
Graduate Medical Education Program”**

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American Academy of Pediatrics

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Chairman Burgess, Ranking Member Green, and members of the subcommittee, thank you for holding this hearing on legislation that is critical to training 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 a primary care pediatrician that specializes in the care of children with special health care needs. Throughout my career, I have made medical education a central focus of my work. I am currently a Professor of Pediatrics and 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 non-profit professional organization of over 66,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults.

The American Academy of Pediatrics strongly supports H.R. 5385, the *Children's Hospital GME Support Reauthorization Act of 2018*, and appreciates the opportunity to share our views with the subcommittee today. We particularly want to thank Chairman Burgess and Ranking Member Green for sponsoring this important legislation.

The Importance of Pediatric Graduate Medical Education

Children are not just little adults; they require medical care that is appropriate for their unique needs. Pediatricians, a term that includes primary care 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 education, followed by residency training of at least 3 years of “hands on,” intensive medical training devoted solely to all aspects of medical care for children, adolescents, and young adults. All told, this training to become a primary care pediatrician consists of approximately 12,000 to 14,000 hours of clinical training.

After board certification in general pediatrics, pediatricians may elect to complete fellowship training—of usually at least another 3 years—to become a pediatric medical subspecialist. The training required of pediatric medical subspecialists prepares them to take care of children with serious diseases and other specialized health care 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 hematologists/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 and development, as well as behavioral issues. Pediatric specialists must also be trained in the care of not just children, but appropriate interaction and shared-decision making with parents, family

members, and other guardians. As a result of advances in medical care, the United States has greatly increased the survival of children in general, including those with special health care needs. These children require specialist physicians with expertise in complex and specialty care to meet their healthcare 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. Federal funding of graduate medical education benefits everyone. Medical training is a costly endeavor, but is one that 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. Teaching hospitals also provide 37% of all charity care in the United States, making medical training, or graduate medical education (GME), programs essential in expanding access to uninsured and underserved populations.

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 CHGME 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.

Critical Shortages in Pediatric Subspecialty Care

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 health care needs. Unfortunately, these shortages severely impact patient care. Primary care pediatricians report having difficulty locating trained subspecialists to whom they can refer their patients. 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. We must do more to address these shortages. Ultimately, we hope to work with Congress to raise the caps on the number of GME slots and to ensure that both pediatric primary care and pediatric subspecialty training are fully funded.

However, 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. After completing their primary care residencies, pediatricians often have an economic incentive to immediately enter clinical practice and draw a salary rather than to embark on subspecialty training that may paradoxically result in lower lifetime earnings compared to primary care pediatrics. We must do more to address these negative incentives. Solutions include offering loan repayment for

pediatric subspecialists and improving Medicaid provider payment rates which are unacceptably low compared to Medicare.

The Future of Graduate Medical Education Funding

Ensuring that the authorization for the CHGME program is extended beyond its current expiration at the end of September is the urgent priority currently before Congress. However, we ask the subcommittee to also think long-term about ensuring that federal GME policy is optimally suited to ensure quality, stable funding for pediatric medical education. CHGME still offers substantially less funding than Medicare GME on a per resident basis. Public funding of GME should not value medical training for children any less than medical care for adults. The health care of children is no less complex. We call on Congress to remedy this inequity.

Additionally, while Medicare GME is a mandatory funding stream, CHGME is a discretionary program that not only requires Congress to reauthorize it every five year, but also requires pediatric advocates to advocate for funding every year in the appropriations process. We urge Congress to enact a stable and predictable funding mechanism for pediatric GME.

The AAP looks forward to working with the subcommittee to ensure quick passage of the *Children's Hospital GME Support Reauthorization Act of 2018*. Thank you for the opportunity to share our thoughts with you today.