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January 31, 2025

The Honorable Bill Cassidy, MD
455 Dirksen Senate Office Building
Washington, DC 20510

The Honorable John Cornyn
517 Hart Senate Office Building
Washington, DC 20510

The Honorable Catherine Cortez Masto
520 Hart Senate Office Building
Washington, DC 20510

The Honorable Michael Bennet
261 Russell Senate Office Building
Washington, DC 20510

Dear Senators Cassidy, Cortez Masto, Cornyn, and Bennet:

On behalf of the nation's more than 200 children's hospitals and the children and families we serve, thank you for providing this opportunity to provide comments on your draft legislation to improve the Medicare Graduate Medical Education (GME) program. The Children's Hospital Association (CHA) applauds you for your commitment to strengthening the physician workforce and looks forward to working with you on this and other efforts to advance workable and effective strategies that increase children's access to needed care.

Medicare GME supports the training of close to 50% of the nation's pediatricians and pediatric subspecialists. Medicare GME provides important support to those children's hospitals in larger academic medical centers that train pediatric residents but are not eligible for CHGME because their parent institutions do not primarily serve children under the age of 18. Though CHGME-trained providers often work at those institutions, the medical centers rely on Medicare GME to support their pediatric residency programs and play a central role in training the next generation of pediatric providers. It can – and must – play a role in addressing serious, ongoing shortages of pediatric medical subspecialists, pediatric surgical specialists, and pediatric mental health providers across the United States. Those shortages are directly impacting access to equitable care for children, especially those with serious, chronic or complex health care needs.

A 2023 Children's Hospital Association (CHA) assessment of pediatric workforce vacancies and appointment wait times at children's hospitals across the country found pediatric physician vacancies in a number of critical specialties. Shortages in four of those specialties are almost unchanged from those identified in 2017. Three out of four shortages that were reported as most severe are in neurological, behavioral, and mental health specialties.

Children are facing wait times as long as 20+ weeks for a geneticist or a developmental-behavioral pediatrician and more than 14 weeks for an appointment with a pediatric neurologist. The shortages are particularly pronounced in behavioral health, with children waiting 10 weeks for a child and adolescent psychiatry appointment, at a time when the nation continues to experience a child mental health emergency.

While our comments below focus on the particular aspects of your draft bill that can be refined to bolster pediatric training through the Medicare GME program, we also urge you to support the Children's Hospitals Graduate Medical Education (CHGME) program. CHGME, administered by the Health Resources and Services Administration (HRSA), is the primary pediatrics training program for pediatricians and pediatric subspecialists. The CHGME program has enabled its 59 participating children's hospitals to dramatically increase pediatric physician

training and increase the number of pediatricians and pediatric subspecialists who care for the nation's children. Bolstering CHGME is key to removing barriers to children's access to both physical and mental health care.

As noted above, the workforce shortages in pediatrics are different than those for adults, primarily affecting pediatric specialty providers. Policies that are adult and primary-care focused will not mitigate ongoing pediatric shortages. To help address these shortages, we highlight some key considerations for the pediatric medical training that is supported by Medicare GME in our responses to certain relevant questions you have proposed.

Is the 30-slot cap appropriate for ensuring fair distribution of residency slots across hospitals? What other strategies could Congress consider to ensure hospitals in all regions have an equal opportunity to compete for slots?

We support a robust increase in the number of Medicare GME positions, including increases in psychiatry slots, particularly in child and adolescent psychiatry. The number of Medicare residency positions has been effectively frozen for a quarter century and has not reflected changes in population, need, workforce shortages, etc. It is critical that additional slots are distributed in such a way as to help address the unique shortages that affect the pediatric subspecialty and mental health workforce, particularly providers that serve underserved populations, including children.

It is important to note that federal Health Professionals Shortage Area (HPSA), Medically Underserved Area (MUA) and Medically Underserved Population (MUP) designations do not adequately reflect the reach of children's hospitals and their staff, including residents and fellows, in underserved neighborhoods. Children's hospitals in academic settings employ a large number of pediatric subspecialty providers, so the precise areas in which they are located are often not considered underserved areas or geographic areas with underserved populations, per se. However, pediatric subspecialty care is regional in nature and pediatric academic medical centers typically serve large geographic areas, including rural and underserved areas. In fact, more than one-half of the children cared for at a children's hospital are covered by Medicaid and travel to the hospital from a low-income community.

We encourage you to consider additional measures for the distribution of additional slots that more accurately reflect the patient populations <u>served</u> by pediatric academic medical centers and are not solely based on geographic location designations. For example, awardees of loan repayment under the recently implemented Pediatric Subspecialty Loan Repayment Program – the only federal loan repayment program focused on pediatric providers – must be located in <u>or serve</u> HPSAs, MUAs or MUPs. Providers can meet this requirement by demonstrating that they serve Medicaid recipients, regardless of whether they are located in a designated MUP area.

Is codifying remote supervision the best way to provide flexibility to rural hospitals, or are there alternative approaches Congress should consider?

We support codifying virtual supervision to allow a teaching physician to have a virtual presence in teaching settings. Allowing virtual supervision facilitates access to care, particularly in underserved communities, helps increase the workforce capacity of teaching children's hospitals, and improves resident skills training in the provision of telehealth services.

During the COVID-19 public health emergency – which established the virtual residency flexibilities – and in their current extension, pediatric residents have been virtually supervised safely and effectively, including instances when the resident provides telehealth services to the patient. Virtual supervision allows the same safe oversight by the teaching physician as having the teaching physician and resident in the same physical location. In addition, there are

guardrails that have been put in place by the Accreditation Council for Graduate Medical Education that ensure patient safety and quality of care when residents are virtually supervised.

The virtual supervision of residents has helped to alleviate the ongoing, and significant, pediatric specialty physician health care workforce shortages facing the nation. In particular, the ability of pediatric specialists to provide their expertise via telehealth is a vital tool in treating children with rare and complex clinical conditions. These children and their families often face barriers accessing care that is timely and coordinated given the range of specialists and subspecialists that may be involved in their care and the regionalized nature of pediatric specialty care. Telehealth can help reduce the frequency of those far-from-home visits and is a crucial tool to help maintain children's access to care without having to travel long distances.

Are the proposed data categories in Section 7 sufficient for understanding the GME landscape without overburdening small hospitals? Are there other useful data points or reporting methods that should be included?
The proposed data categories in Section 7 are all currently reported by teaching hospitals that receive Medicare GME to the federal government or accrediting bodies. We believe it is important to use existing sources of data and not require duplicative and unnecessary additional reporting.

Additional comments
Our ability to continue to meet children's health care needs, now and into the future, requires innovative approaches to bolster our current and future pediatric providers. We must have a national commitment to, and investment in, the nation's pediatricians and pediatric subspecialists to ensure that our health care system can deliver optimal care to children.

However, children's hospitals participating in the CHGME program, which is vital to supporting the training of pediatricians and pediatric subspecialists, receive significantly less per resident funding than those that receive funding through Medicare GME or other adult-focused training programs. This funding discrepancy limits the number of resident positions that can be supported and incentivized, impacting the resources available for training and research, which is critical for addressing the nation's pediatric workforce shortages and advancing pediatric care. Therefore, we urge you to support increased funding for the CHGME program even as you work on this legislation and other initiatives to strengthen the Medicare GME program.

Thank you for this opportunity to provide comments on your Medicare GME draft. We look forward to working with you on workable solutions to the pediatric subspecialty shortages facing the nation that will enhance children's access to needed care. Please contact Jan Kaplan at jan.kaplan@childrenshospitals.org or 202-753-5384 if you need additional information.

Sincerely,

Aimee Ossman
Vice President, Policy
Children's Hospital Association