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Pediatric Workforce Funding: Overview & Recommendations

Each year, California's eight private, non-profit, free-standing children's hospitals train approximately 50% of the state's pediatric residents and nearly 10% of all fellows. They also provide pediatric rotations for hundreds of family medicine residents annually, often at no cost to the residents' sponsoring institutions.

A Shortage of Pediatric Physicians

The state currently has a shortage of pediatric primary care and pediatric specialty care physicians. According to the American Academy of Pediatrics, "the current distribution of primary care pediatricians is inadequate to meet the needs of children living in rural and other underserved areas, and more primary care pediatricians will be needed in the future because of the increasing number of children who have significant chronic health problems, changes in physician work hours, and implementation of current health care reform efforts that seek to improve access to comprehensive patient- and family- centered care for all children in a medical home." Similarly, the Council on Graduate Medical Education recommends between 60-80 doctors per 100,000 people in the population, but in California, very few regions meet that threshold. The average number of primary care physicians in the state in 2015 was 57 per 100,000 people, down from 68 in 2008. The numbers of family physicians and OB/GYNs grew slightly during that time, but the number of general internists and general pediatricians declined.

The picture for pediatric specialty care is even more bleak. In a recent survey of its membership, the Children's Specialty Care Coalition (CSCC), which represents the state's pediatric specialty care physicians, found that for 19 practice areas, the average wait time for an appointment ranged from 16 days for orthopedics and hematology/oncology to 73 days for medical genetics. They similarly found that pediatric medical groups face significant challenges in trying to recruit new specialists, with recruitment times ranging from 14 months for a pediatric general surgeon or allergist to as much as 24 months for a pediatric cardiothoracic surgeon or dermatologist. These shortages are apt to worsen significantly over time. CSCC expects the number of children with complex medical conditions to increase 100 percent over the next 10 years, as these children live longer due to advances in medicine and medical technology.

Federal Funding for Pediatric Residencies

Most hospitals that train residents receive enhanced Medicare payments for their Medicare patients to help cover the additional cost associated with training residents. This funding benefits hospitals that train family medicine, OB/GYNs, and internal medicine residents. However, since children's hospitals serve almost no Medicare patients, they receive very little Medicare graduate medical education (GME) funding[i]. For example, in 2016, California hospitals received $744 million in Medicare GME, of which CCHA's member hospitals received only $90,500.

The federal government does have a special GME program for children's hospitals (CHGME), but that program provides significantly less reimbursement per residency slot than Medicare does. In fact, the average CHGME payment per full-time equivalent resident represents less than 60% of what Medicare GME provides to support training in adult teaching hospitals.

CCHA's eligible member hospitals received $37.4 million in federal CHGME funding in 2016, 4.8% of all federal GME funding that went to California hospitals that year. Residency slots cost a minimum of $100,000 per year to offer. This means that the federal government is funding approximately 7,400 residents a year at Medicare hospitals while only funding around 280 residencies at children's hospitals. Meanwhile, children make up nearly a quarter of the population, and over half of them are enrolled in the state's Medi-Cal program.

In addition, unlike Medicare GME, CHGME requires an annual budget appropriation from Congress, meaning that children's hospitals are never sure whether sufficient funding will be available to continue their programs from year to year. Trainees in children's hospitals can lose their positions if there is a decrease in the appropriation for CHGME, which has happened 5 times since 2000.

State Funding for Pediatric Residencies

The Song Brown Program

California currently has two main GME programs. The oldest of the two is the Song Brown program, which was established in 1973 to expand the primary care workforce in areas of unmet need around the state. The program originally focused on family medicine residencies, but was expanded to include pediatrics, internal medicine, and obstetrics and gynecology in 2014. This program relies on annual appropriations as part of the state budget process. In 2017, state lawmakers significantly expanded the program with an allocation of $100 million spread over three years. This funding will run out after the 2019-20 fiscal year unless it is extended as part of the 2020 budget agreement.

Unfortunately, at the same time as overall funding for the Song Brown program has gone up in recent years, pediatric residency programs have been receiving a significantly smaller share of the available funding. In 2015 and 2016, for example, pediatric residency programs received at least 30% of the available funding each year, but since then, they have received just 4% of the available funding, or approximately $1 million per year. This shift reflects a recent policy change made by OSHPD in the methodology for awarding these grants. In late 2017, the California Healthcare Workforce Policy Commission, which reviews funding applications and makes recommendations to OSHPD's Director about how to award Song Brown grants, recommended changes to the Song Brown program application that caused pediatric programs to score lower than family medicine programs. The rationale for the change was that family medicine physicians all go on to practice in primary care, which is the focus of the Song Brown program, while approximately half of all pediatricians go on to specialize. However, given how little funding the Song Brown program gives to any one residency program, it never comes close to funding even half the slots at the state's smaller pediatric residency programs, and thus is at little risk of funding pediatric specialist training. Furthermore, there are ways to target GME grants to pediatric programs that focus on training pediatricians for primary care placements rather than excluding pediatric programs altogether.

Notably, if pediatric residency programs had received a similar percentage of the dollars in this round as they did in earlier rounds, they would have received over $9 million. Pediatric programs also received

smaller average grants than they did in earlier funding rounds, and significantly less than the average grant amount awarded to non-pediatric programs in this funding round.

In addition, not all children's hospitals receive Song Brown funding despite the significant role they play in training pediatricians. For example, a number of them score lower on the application because they are not located in medically underserved areas (MUAs), they do not serve large enough medically underserved populations, (MUPs) or they are not located in a primary care shortage area (PCSA). These requirements of the program pose a larger barrier to pediatric residency programs, because there are fewer of these programs, each teaching a larger share of the overall pool of residents than is the case for residency programs in the other 3 primary care program types. As a result, when a few pediatric programs miss out on funding due to their location and patient mix, a significant share of all pediatric slots go unfunded, but the same is not true for family medicine, internal medicine and obstetrics and gynecology programs.

Proposition 56 and Physicians for a Healthy California

In November 2016, California voters approved Proposition 56, which increased the tax on tobacco products and established an equivalent tax on e-cigarettes and other vaping products. The revenue generated by this tax increase is largely dedicated to increasing payments to Medi-Cal providers, but the measure also set aside $40 million each year[ii] for GME. It directed those funds to the University of California (UC), but also indicated that all federally accredited allopathic and osteopathic residency programs in the state are eligible for the funds. The UC subsequently entered into a memorandum of understanding (MOU) with the California Medical Association (CMA), placing the CMA's foundation, Physicians for a Healthy California, in charge of developing a distribution methodology and application process for the funds. The MOU also established a 15-member advisory council, on which CCHA has a seat, and a 5-person board that makes final decisions about grant awards each year.

Like the Song Brown program, the Proposition 56 GME program is focused on increasing the number of primary care physicians in the state in the four primary care specialty areas of pediatrics, internal medicine, family medicine, and obstetrics and gynecology. However, it also provides funding for emergency medicine residents. This program also differs from Song Brown in that its advisory committee has chosen to set aside specific pots of money for each of the five specialties to ensure that none are disadvantaged in the application process. In the first year of the program, for example, each of the five residency types received 20% of the available funding, or approximately $8 million. In year two, based on the variation in demand among applicant types in year one, the advisory council recommended a change in that distribution allocation. As a result, in 2019, family medicine residency programs will receive approximately $9.5 million, pediatrics, internal medicine and emergency medicine programs will each receive approximately $7.6 million, and obstetrics and gynecology programs will receive $5.7 million.

It is worth noting that in its first year, the program received $174 million in requests – over four times the available funding.

Conclusion & Recommendations

Residency slots cost over $150,000 per year to provide. The federal government is funding approximately 7,400 residents a year at Medicare hospitals while only funding around 280 residencies at

children's hospitals. At the same time, the Song Brown program funds approximately 300 adult residency slots compared to 10 pediatric slots each year, and Proposition 56 funds between 75-80 pediatric slots each year, compared to 300+ adult residency slots. Meanwhile, children make up 23% of the state's population, and over half of them are enrolled in Medi-Cal. The state arguably needs to invest much more heavily in pediatric residencies to compensate for the lack of federal funding for them, and to keep up with the demands of the population. What's more, neither of the state's GME programs provide funding to train pediatric specialists, who are in the most short supply. CCHA believes it is critical that the state support all types of primary care physicians, including pediatricians and pediatric specialists, to ensure that the state's children are able to access the care they need in the years to come.

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[i] Training for physician residents is known as graduate medical education, or GME.

[ii] This amount will decline as revenue from the tobacco tax declines. In 2019, for example, only $38.7 million was available for GME.