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July 12, 2023

The Honorable Cathy McMorris Rodgers
Chair
House Energy & Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
House Energy & Commerce Committee
2322 Rayburn House Office Building
Washington, DC 20515

The Honorable Brett Guthrie
Chair
Health Subcommittee
House Energy & Commerce Committee
2434 Rayburn House Office Building
Washington, DC 20515

The Honorable Anna Eshoo
Ranking Member
Health Subcommittee
House Energy & Commerce Committee
272 Cannon House Office Building
Washington, DC 20151

Dear Chair McMorris Rodgers, Ranking Member Pallone, Chair Guthrie and Ranking Member Eshoo,

On behalf of the more than 200 nation's children's hospitals and the millions of children and families we serve, the Children's Hospital Association is submitting this letter for the Health Subcommittee markup on July 13. We understand the subcommittee will be taking up a number of bills that will help the patients and families children's hospitals and the specialized physicians important to their care serve, such as the PREEMIE Reauthorization Act and the Sickle Cell Disease and Other Heritable Blood Disorders Research, Surveillance, Prevention and Treatment Act. However, we want to focus our comments on two bills in particular, H.R. 3887 and H.R. 4421, Preparing for All Hazards and Pathogens Reauthorization Act.

Children's Hospitals Graduate Medical Education Reauthorization

As we have shared before, we urge the committee to promptly move legislation to reauthorize the Children's Hospitals Graduate Medical Education (CHGME) program, the only federal program focused exclusively on the training of pediatricians and pediatric specialists, without making any policy changes to this vital program. CHGME is critical to the national goal of providing needed care for America's children, including children in military families and those in underserved rural and urban communities. To this end, **we support Rep. Schrier's bill, H.R. 3841, which is a clean, five-year reauthorization of CHGME.** In doing so, Congress can build upon its legacy of overwhelming bipartisan support for reauthorizing this critical program. We appreciate Rep. Schrier introducing H.R. 3841 and look forward to it moving promptly and in a bipartisan fashion.

As we face a critical pediatric provider shortage, CHGME is vital to ensuring our children and their families have access to the routine care they need. The purpose of the program is to train doctors. How physicians provide care is dependent on the scope of state law and what is supported by medical evidence in consultation with consenting families. **CHA opposes tying the availability of physician training funding to any type of care provided at a hospital independently of its training programs as is suggested in H.R. 3887, which is why we oppose this legislation.** To do so only threatens the critical pipeline of needed pediatricians that CHGME supports.

Congress created the bipartisan CHGME program in 1999 recognizing that a dedicated source of support for training pediatricians and pediatric specialists in children's hospitals was key to building and sustaining a robust pediatric workforce and providing access to care for our nation's children. CHGME was established specifically to address the disparity between the funding that adult-focused hospitals access through Medicare Graduate Medical Education (GME) and the funding

children's hospitals receive to train the pediatric physician workforce. Because children's hospitals care for extremely few children covered by Medicare, they receive very little Medicare GME funding—the primary source of federal support for training physicians. Before CHGME, pediatric physician training programs suffered from minimal federal support, leading to shortages of pediatricians which created access to care challenges for children. These challenges continue today.

Children's hospitals are pediatric workforce training hubs, responsible for training the next generation of pediatricians and pediatric specialists as well as pediatric nurses, therapists, advanced practitioners and technicians. They also serve as a vital safety net for all children regardless of insurance status, including those that are uninsured, underinsured and enrolled in Medicaid and the Children's Health Insurance Program (CHIP). Children's hospitals serve the majority of children with serious, chronic and complex conditions, **providing 95% of all pediatric cancer care**, and care to most children in need of major surgery.

CHGME children's hospitals have the patient volume necessary to train pediatric specialists. The residents and fellows whose training is supported by CHGME learn from experienced pediatric-focused practitioners, gain hands-on experience treating highly complex cases and participate in pediatric research ensuring the highest quality of care.

The Success of CHGME

Since its inception, CHGME has enabled children's hospitals to dramatically increase pediatric physician training overall and grow the supply of pediatric specialists. The 59 children's teaching hospitals that now receive CHGME support train **more than half of all pediatricians and pediatric subspecialists**, including pediatric cardiologists, child and adolescent psychiatrists and pediatric oncologists. In some fields, such as pediatric rehabilitation medicine, virtually all physicians receive their training at CHGME children's hospitals. CHGME children's hospitals also train adult medical specialists, such as family medicine residents, who rotate through for their pediatrics training. In 2022, **over 15,000 pediatric residents trained in CHGME children's hospitals**.

Furthermore, CHGME is critical to the national goal of providing comprehensive and timely access to care for all of America's children. CHGME-trained physicians provide critical access to care to **children in military families and children in underserved rural and urban communities, serve as medical homes and address health care disparities**. Although CHGME-funded hospitals make up just 1% of all hospitals nationwide, these hospitals provide close to one-third of the inpatient hospital care received by children covered by Medicaid.

It is also important to note that approximately **60% of CHGME-funded physicians** who complete their training programs choose to practice in the states where they complete their residency – ensuring access to care for some of the most underserved children. This was critically important as the COVID-19 pandemic, RSV and the children's mental health crisis exacerbated existing pediatric workforce shortages and created a record-breaking demand for access to children's health care.

The Continuing Need for CHGME

While the CHGME program has helped the nation make great strides toward a more robust pediatric workforce to care for all children, serious shortages in many pediatric specialties persist. Addressing those shortages by bolstering our pediatric workforce training programs is more important than ever as our nation's youth are grappling with a worsening mental, emotional, and behavioral health crisis. We cannot keep up the momentum to enhance the pediatric workforce and remove barriers to children's access to both physical and mental health care without the CHGME program. **Therefore, we, again, encourage the committee to pass a CHGME reauthorization without making any policy changes.**

Pandemic and All-Hazards Preparedness Act Reauthorization

As the committee works towards a PAHPA reauthorization, we encourage you to prioritize the distinct needs of children, who represent some **25% of the total U.S. population**. Ensuring that the unique physical and mental health needs of children are met during a pandemic or other public health emergencies must be a major part of Congress' work to reauthorize the Pandemic and All-Hazards Preparedness Act (PAHPA).

Over the last few years, children's hospitals have experienced unprecedented pediatric volumes driven by a substantial increase in childhood respiratory illnesses, like respiratory syncytial virus (RSV), and the ongoing surge in mental health visits. The challenges that confronted children's hospitals and their nimbleness to respond demonstrate how critical it is that the nation's pandemic preparedness system can appropriately account for differences between the way physical and mental health care delivery and support systems are structured for children compared with adults.

Pediatric-specific needs in an emergency preparedness and response system

Children are not little adults, and their physical and mental health care needs, the delivery system to meet those needs and their support systems (e.g., schools, childcare settings, etc.) are different from those of adults. Children are constantly growing and developing, and child-appropriate care will support that healthy development. Disruptions in their care, trauma, social isolation, financial, food and housing insecurity and grief associated with a natural disaster or pandemic can have a significant negative impact on children's mental and physical health and their long-term well-being. This is especially true for children and families in underserved, under-resourced and racial and ethnic minority communities. Children are also dependent on their caregivers, and the needs of their parents or guardians must be considered in a pediatric care framework.

Furthermore, pediatric care typically requires extra time, monitoring, specialized medications and equipment, and specially trained health care providers who are compassionate and understand kids of all ages and from all backgrounds. Children's hospitals, unlike adult-focused medical facilities, are increasingly the only places in their state and region with the breadth of pediatric specialists and subspecialists, the pediatric-appropriate medical equipment, and other resources required to treat children, particularly those with rare and complex clinical conditions. Given the regionalization of pediatric specialty care, children's hospitals' critical care and "surge" capacity for children is limited during a widespread public health emergency (PHE), such as a pandemic or natural disaster, adding a significant level of complexity to the nation's capacity to meet children's needs.

There must be a pediatric-focused national framework for preparedness and response efforts that has the capacity both during a PHE and in the absence of one that strengthens pediatric capacity, addresses pediatric workforce shortages and allows for the triage/consolidation of pediatric patients to centers best designed for their care.

Congressional Action Needed

A key component of the future of pediatric care will be the development of a national disaster response infrastructure that adapts to the changing landscape of health emergencies while remaining focused on the goal of providing comprehensive and high-quality services to deliver optimal child health. Solutions must be pediatric-specific. Several key opportunities within PAHPA to address pediatric pandemic and disaster preparedness and relief strategies are highlighted below.

Target Hospital Preparedness Program (HPP) resources to meet pediatric needs. The HPP must target resources for children's hospitals and children's health care systems to plan for and respond to pediatric needs in large-scale emergencies and disasters. The regionalization of pediatric specialty care adds a significant level of complexity to the nation's capacity to meet children's needs. It is imperative that children's hospitals' critical care capacity is supported and that communities without a children's hospital have operational capacity to meet children's basic needs during a pandemic or natural disaster.

Therefore, Congress should direct ASPR to develop and disseminate "pediatric toolkits" through the HPP to non-pediatric hospitals that include pediatric-appropriate equipment (such as smaller sized, cuffed endotracheal tubes used for advanced airway management and emergent mechanical ventilatory support), training modules, as well as dosages and usages of therapeutics (such as smaller doses of albuterol) to successfully handle surge capacity and any transferred child-patient. Furthermore, non-pediatric hospitals should have pediatric interfacility transfer agreements and interoperability capabilities to allow for electronic access to specialized pediatric clinical and mental health care providers for remote consultations.

Transparency in the Strategic National Stockpile for pediatrics. Congress should ensure that the Strategic National Stockpile has the tools to accurately track its contents, including pediatric medical and health supplies.

Enhance pediatric-specific training opportunities in the Medical Reserve Corps (MRC). Investments must be made to address the current and long-term pediatric workforce challenges, so these shortages do not happen in future pandemics. We encourage you to consider mechanisms to ensure that the MRC program is equipped to meet the unique needs of the pediatric population, particularly children with medical complexities, which can fill critical workforce needs during a pandemic or natural disaster with volunteers in an emergency or when there are other emergency staffing needs.

As the committee continues its legislative process, we urge the committee to promptly move Rep. Schrier's legislation (H.R. 3841) to reauthorize CHGME without making policy changes to this vital program. CHGME is an essential training program for our country's pediatric health care system and is vital to ensuring children now and in the future have access to the specialized care they need. Additionally, pandemic and disaster preparedness efforts throughout government must be aligned, coordinated, strengthened and adequately funded to support a shared pediatric mission and framework. Children's hospitals stand ready to partner with you to advance policies that will make measurable improvements in the lives of our nation's children. Children need your help now.

Sincerely,

Leah Evangelista
Chief Public Affairs Officer
Children's Hospital Association