

Political Tug-of-War and Pediatric Residency Funding

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On October 1, 2013, without a continuing resolution in place to support its budget, the U.S. federal government partially closed. One of many effects of the government shutdown was the defunding of the Children's Hospitals Graduate Medical Education (CHGME) Payment Program. Fifty-five freestanding children's hospitals currently receive CHGME funds. These hospitals train almost 30% of the general pediatricians, 44% of the pediatric medical and surgical subspecialists, and the majority of the pediatric physician-researchers in the United States.^{1,2} Capable of providing highly specialized care for pediatric patients with complex and acute conditions, freestanding children's hospitals are at the apex of many pediatric referral networks.³ The sudden lapse in

The CHGME program was created in 1999 under the Healthcare Research and Quality Act to provide financial support for GME at eligible freestanding children's hospitals.² Historically, Medicare GME subsidies have been linked to care provided at teaching hospitals for Medicare beneficiaries, who are, with rare exception, adults. As a result, over the years since the inception of Medicare in 1965, freestanding children's hospitals had received essentially no federal support for residency or fellowship training. The CHGME program was developed to provide partial parity in federal funding for training programs at these hospitals by creating a process similar, but not identical, to Medicare GME. One key difference between the two programs is that the Medicare GME program

(see graph).⁴ Like all federal appropriations for the past 4 years, those for the CHGME Payment Program have depended on continuing resolutions rather than actual budgets passed by Congress. Reductions and delays in the receipt of CHGME funds have resulted in fluctuations of millions of dollars for individual children's hospitals.

Health care systems are financially complex, operating through a tangle of internal cross-subsidies as they aim to achieve multiple missions in service, education, and research. A sudden change in any single revenue stream can therefore have broad and uncertain effects. In 2008, the American Academy of Pediatrics (AAP) released a policy statement calling for the CHGME program to be funded in a more predictable and sustainable manner.¹ The AAP also recognized the need for increased transparency and accountability on the part of teaching hospitals regarding the way they use their federal subsidies. Many children's hospitals funded by the program have undergone recent growth thanks to generous endowment funding, but the size of these endowments and hospitals' cost-shifting practices vary substantially. The extent to which hospitals should devote these endowments and funding from other sources to GME rather than to their other missions is debatable.

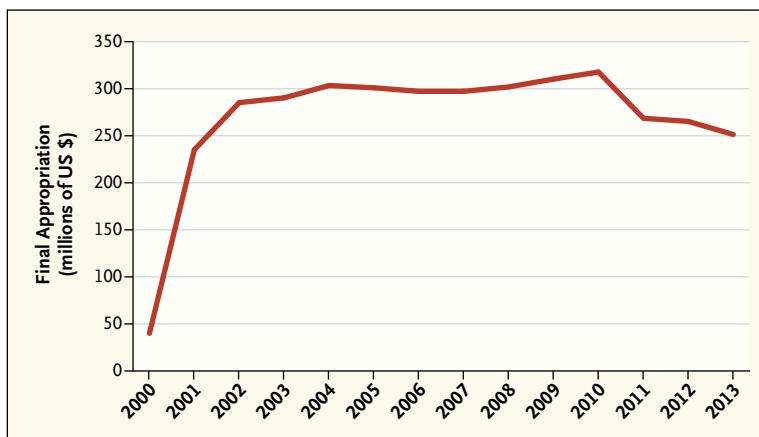
Once federal GME funds have been appropriated, the method of distributing them is also different for freestanding children's

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CHGME funding represents only the most recent financial challenge for children's hospitals providing residency training and highlights the danger of subjecting the larger universe of Medicare funding for graduate medical education (GME) to a highly politicized process.

is financed through the Medicare Trust Fund, and the CHGME Payment Program relies on annual funding allocated through the political process of annual congressional appropriations.²

Over the past 3 years, the amount appropriated to children's hospitals has declined by 21%



Funding of the CHGME Payment Program.

Data are from the Children's Hospital Association.

hospitals than for other teaching hospitals. Critics of the Medicare GME program argue that its approach leads to inequity because it is based primarily on the percentage of a hospital's patients who are covered by Medicare and the number of residents in each hospital.⁵ The CHGME program also bases its direct medical-education payments on the number of residents, but it uses a more multifaceted formula for calculating the indirect medical-education payments that support teaching hospitals' noneducational functions and per-patient costs that are higher than those of other hospitals.^{1,4} Despite these accounting differences, neither program's financing mechanisms are clearly aligned with important goals of GME, including managing the overall size of the physician workforce and its specialty and geographic distribution.⁵ The apparent disconnect between the incentives created by federal GME subsidies and the size and structure of the workforce that is produced has caused many people to wonder what role public funding should have in physician training.

Central to the issue of who

funds GME is the question of who benefits from it. Physicians, academic hospitals, and training programs argue that physician training serves us all — and that pediatricians-in-training, in particular, will work to protect vulnerable children.¹ Our ability to have the health care we want for our children and ourselves depends in part on paying for the training that ensures that there will be people who can deliver these services. Economists, however, point out that physicians effectively pay for their own training, during which they work at below-market wages, and that the skills they develop in training accrue to them, are portable, and are essentially resold to patients or the insurers or employers who pay for their care.⁵ Although pediatricians might differ with economists over whether the care they deliver is a public good, there may well be general agreement that we're all better off if we don't subject the funding of children's health care to the vicissitudes of the political process — especially given the way that process has played out recently. At the very least, perpetually un-

certain financing is a problem, and “financial smoothing” would be advantageous to everyone.

The GME quagmire resulting from the government shutdown should serve as a warning. Critics of the Medicare GME funding process who call for a more appropriations-based system might take notice that the children's hospitals program is required to battle annually to protect its funding and continue pursuing its mission of protecting children's health and well-being. Several solutions to the uncertainty of CHGME funding have been proposed, including creating an all-payer GME trust fund, giving the CHGME program the same entitlement status as the Medicare GME program, and eliminating all public GME funding.¹ This last approach deserves close scrutiny; if GME training were moved out of the public domain, the availability of trainee education would depend on clinical revenue — with grim implications for less-lucrative fields such as primary care. At the very least, if Americans no longer want to provide federal support for training pediatricians, it would help children's hospitals to be given some advance notice of such a change.

With this year's CHGME funding appropriation far from certain, pediatric residents and fellows are being paid out of clinical and other reallocated revenue — which undoubtedly creates pressures in other parts of the children's health care system. Though this stopgap measure helps to continue the training of pediatricians and the care of their patients, we hope that in the future, GME funding can avoid being caught in this type of political tug-of-war.

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Housing as Health Care — New York's Boundary-Crossing Experiment

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Among the countries in the Organization for Economic Cooperation and Development (OECD), the United States ranks first in health care spending but 25th in spending on social services.¹ These are not two unrelated statistics: high spending on the former may result from low spending on the latter. Studies have shown the powerful effects that “social determinants” such as safe housing, healthful food, and opportunities for education and employment have on health. In fact, experts estimate that medical care accounts for only 10% of overall health, with social, environmental, and behavioral factors accounting for the rest.² Lack of upstream investment in social determinants of health probably contributes to exorbitant downstream spending on medical care in the United States. This neglect has ramifications for health outcomes, and the United States lags stubbornly behind other countries on basic indicators of population health.

The role of social determi-

nants of health, and the business case for addressing them, is immediately clear when it comes to homelessness and housing. The 1.5 million Americans who experience homelessness in any given year face numerous health risks and are disproportionately represented among the highest users of costly hospital-based acute care. Placing people who are homeless in supportive housing — affordable housing paired with supportive services such as on-site case management and referrals to community-based services — can lead to improved health, reduced hospital use, and decreased health care costs, especially when frequent users of health services are targeted.^{3,4} These benefits add to the undeniable human benefit of moving people from homelessness into housing.

With runaway Medicaid costs crippling states throughout the country, leaders are looking for innovative solutions to bend the cost curve. We in New York State are testing one such innovation: investment in supportive housing for high-risk homeless and un-

stably housed Medicaid recipients. These recipients include not only people living on the streets or in shelters but also thousands boarding in nursing facilities, not because they need the level of care provided but because they lack homes in the community to which they can return. New York Medicaid payments for nursing-facility stays are \$217 per day, as compared with costs of \$50 to \$70 per day for supportive housing. Furthermore, preventing even a few inpatient hospitalizations, at \$2,219 per day, could pay for many days of supportive housing.

Supportive housing is part of a larger Medicaid Redesign effort that was initiated by Governor Andrew Cuomo in January 2011. An Affordable Housing Work Group including representatives from more than 20 organizations discussed barriers to implementing supportive housing and identified solutions. The group's final recommendations for state government action included providing integrated funds for capital, operating expenses, rent subsidies, and services in new