ACTPCMD

Advisory Committee on Training in Primary Care Medicine and Dentistry

Tonya Fancher, MD, MPH
Chair

Shane Rogers
Designated Federal Officer

November 6, 2024

The Honorable Xavier Becerra
Secretary of Health and Human Services
200 Independence Ave S.W.
Washington, DC 20201

The Honorable Bernard Sanders
Chair, Committee on Health, Education, Labor and Pensions
United States Senate
Washington, DC 20510

The Honorable Bill Cassidy
Ranking Member, Committee on Health, Education, Labor and Pensions
United States Senate
Washington, DC 20510

The Honorable Cathy McMorris Rodgers
Chair, Committee on Energy and Commerce
House of Representatives
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member, Committee on Energy and Commerce
House of Representatives
Washington, DC 20515

Dear Secretary Becerra, Chairman Sanders, Ranking Member Cassidy, Chair McMorris Rodgers, and Ranking Member Pallone:

The Federal Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD) strongly recommends: 1) permanent reauthorization, with consistent, sustained funding, and 2) an increase per Resident Amount (PRA) to $210K, and implement a mechanism to monitor and increase the PRA, over time, based on a report of actual cost for the Teaching Health Center Graduate Medical Education (THCGME) program (Section 340H, Public Health Services Act).

Recommendation 1: Permanently reauthorize THCGME with consistent, sustained funding. The current THCGME funding model lacks long-term financial certainty. Since the program's inception, THCGME has relied on periodic appropriations by Congress rather than guaranteed funding as a federal entitlement program like Medicare Graduate Medical Education (GME). This uncertainty limits the stability of teaching health centers (THCs) and puts the financial sustainability of existing THCGME programs at risk. The THCGME program, with permanent authorization and sustained funding, would continue to train a workforce in community-based THCs to meet the needs of rural and urban underserved communities.[1]

The Doctors of Community (DOC) Act introduced in 2023 would provide permanent authorization and expansion of the THCGME program. Research suggests that the THCGME program produces a

[1]Training the Primary Care Workforce to Deliver Team-Based Care in Underserved Areas: The Teaching Health Center Program. Accessed 9.29.2023 from https://www.milbank.org/wp-content/uploads/2023/05/THC-Milbank_4.pdf

workforce that delivers cost-effective care to patients most in need, yielding up to $238 million in Medicare savings and $1.2 billion in Medicaid savings over five years.

Based on the evidence of per-person savings for patients served in community health centers, cost savings from THCGME resident visits are estimated at $57.5 million annually. Residency training in lower-cost areas is associated with more cost-efficient care after graduation from residency. Upon graduation from residency, THCGME graduates could reduce medical spending by $169 million annually. Combined savings of the THC program have resulted in an estimated $1.8 billion in Medicaid and Medicare savings from 2019 to 2023.

In 2021, Congress for the first time provided funding for the Teaching Health Center Planning and Development Program (THCPD) as part of the American Rescue Plan Act. The THCPD funding could be modified to mirror Rural Residency Planning and Development funding, which includes a longer start-up time (three or more years) and more funding ($750,000 versus $500,000), per awardee. Additional THCPD awards with increased funding per award and additional years of technical assistance support could be made available to develop more THCs if congressional appropriations are made beyond the one-time American Rescue Plan Act funding.

Recommendation 2: Increase per Resident Amount (PRA) to $210K and implement a mechanism to monitor and increase the PRA based on actual cost.

A 2022 study of HRSA-commissioned THCs conducted by George Washington University found the national median of the true resident training costs is $210,000 per year. If the THCGME reauthorization bill fails to include this kind of increase, some programs may be unable to continue because the current $160,000 per resident amount is too low and puts a financial strain on both the practice and programs to continue seeing patients and training residents. Since training costs increase over time, there should be a mechanism to increase the PRA, based on a yearly report of actual cost to continue to support the THCGME programs.[2] Concomitantly, an amendment to draft Senate legislation would require an increase in the PRA but does NOT provide a concomitant increase in appropriations to account for the increased cost per full-time equivalents (FTE). Any legislation that mandates a statutory increase in the PRA must also increase the total annual appropriation to allow existing programs to fund each of their FTEs and also account for any expansion of the THCGME program from the Congressionally mandated THCPD program, which was initiated in 2021.

The Consolidated Appropriations Act of 2024 provided $219 million for the THCGME Program for FY 2024 and Q1 of FY 2025. In FY 2024, HRSA funded approximately 1,176 FTEs for Academic Year (AY) 2024-2025 and six months of AY 2025-2026.

Congress requires THCGME programs to report their program outcomes annually. This serves as an excellent model for ensuring public investment in training is held accountable and aligned with population health needs. This data shows that the THCGME model produces physicians and dentists

[2] Teaching Health Center Graduate Medical education (THCGME) Cost Evaluation Update, 2022. Accessed 9.29.2023 from PowerPoint Presentation (hrsa.gov)

who practice in communities of need and address the healthcare of underserved populations. These graduates produce substantial savings for the federal government.[3]

In summary, establishing new and maintaining residency programs in rural and underserved areas is time- and resource-intensive. Financial vulnerability, accreditation challenges, and faculty recruitment make it challenging for rural and underserved GME programs to launch programs quickly. Given these challenges, two to three years or more of funding and technical assistance may be insufficient for THCGME development. Organizations may also be reluctant to invest resources in building THCGME programs when there is no guaranteed funding to support the ongoing costs of training residents. Despite these obstacles, THCGME programs continue to add value and provide much needed care for underserved populations at a cost-savings to the federal government. Additional support would accelerate and expand the impact of THCGME programs.

Sincerely,

/s/ Tonya Fancher, MD, MPH
Chair, ACTPCMD

[3] Training the Primary Care Workforce to Deliver Team-Based Care in Underserved Areas: The Teaching Health Center Program. Accessed 9.29.2023 from https://www.milbank.org/wp-content/uploads/2023/05/THC-Milbank_4.pdf