

The Teaching Health Center Graduate Medical Education Program: A Permanent Funding Imperative

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Community Health Centers (CHCs), providers of affordable health care services to underinsured populations, have proven to be an effective model for the integration of primary care and public health services since their inception in the mid-1960s.^{1,2} Upon the 2010 establishment of the Teaching Health Center Graduate Medical Education (THCGME) Program under the Patient Protection and Affordable Care Act (ACA), the partnership between CHCs and primary care residency programs has been markedly amplified. The THCGME, a Health Resources & Services Administration (HRSA)-administered program, funds primary care residency training programs at CHCs. More than 2000 primary care physicians and dentists have graduated and entered the workforce since the inception of the program. During the 2022-2023 academic year, more than 950 residents were in training at 72 THCGME-supported primary care residency programs.³ More than half of THCGME graduates enter practice in a medically underserved community or rural area, compared with less than a quarter of all family medicine residency graduates.^{4,5} Despite this considerable progress, the lack of permanent federal funding for the THCGME program has placed the primary care training in underserved communities in jeopardy.^{6,7} Currently, the THCGME is funded only through September 2023.³ In this Perspective, we review the early years and funding history of the THCGME program, explain the importance of its permanent federal funding, and discuss future legislative prospects thereof.

THCGME Program History

Research and advocacy by primary care physicians in the 1990s and 2000s catalyzed the establishment of the HRSA-administered THCGME program.⁸ The lead mover behind Section 5508 of the ACA, which established the program, was then-Senator Jeff Bingaman (D-New Mexico). The program aimed to expand training in community-based outpatient primary care

settings in rural and underserved areas by subsidizing the costs of resident training in family medicine, internal medicine, pediatrics, internal medicine-pediatrics, obstetrics and gynecology, psychiatry, general dentistry, pediatric dentistry, and geriatrics. The THCGME funding model is distinct from the traditional Medicare-funded GME paradigm. First, the THCGME supports only primary care training programs based in community settings, whereas Medicare-funded GME is directed primarily to teaching hospitals.⁹ Second, because THCGME payments to each THC are determined by specific health care workforce goals, awardee reporting requirements include the number of residents who continue to care for vulnerable populations in underserved communities after the completion of their training.⁹

The program arose out of a failure of GME reform efforts to improve accountability and create a primary care physician workforce particularly for the underserved; its accountability and reporting features remain a potential model for Medicare GME reform. As originally proposed, the THCGME was an entitlement program to be funded by Medicare. However, prior to the eventual approval of the THCGME program, opposition to this funding mechanism resulted in the program's shift into a less stable form of federal spending under the Senate Committee on Health, Education, Labor, and Pensions. The concern underlying this shift was that Medicare dollars would be flowing to sites that did not predominantly treat Medicare patients; HRSA had already administered the Children's Hospitals Graduate Medical Education Program (begun in 1999) for similar reasons. Further opposition argued that the THCGME's inclusion in Medicare GME would result in redistribution and competition between programs rather than an increase in total GME funding and therefore workforce supply.

Why Permanent Funding Is Needed

Since 2010, the THCGME has been funded by Congressional appropriations enacted in several public laws. Although the THCGME is funded through September 2023, the program requires increased and

stable funding to ensure its continued success and impact. Throughout the 2010s, the piecemeal approach to funding the THCGME precipitated numerous budgeting, planning, and recruitment challenges at THCGME-affiliated primary care residency programs.⁴ Population health provision suffered as a result.¹⁰ Funding uncertainty has historically led to fewer patient services, reduced hours of operation, unexpected staff layoffs, unpredictable hiring cycles,¹⁰ and a decrease in THCGME's contribution to the net growth of family medicine residency programs.⁶ Albeit rare, there are examples where funding inadequacy and uncertainty led to the relocation of residents in training and termination of partnerships between primary care residency programs and CHCs.¹¹

When executed with a shared vision of education and service, the partnership between primary care residency programs and CHCs has generally led to cost reduction with improved patient access, a focus on patient safety and social determinants of health, enhanced response to public health emergencies, succession planning responsive to community needs, reduction in burnout and physician turnover, and the creation of an academic culture.¹² A significant portion of residents who choose to train at THCs are from rural or disadvantaged backgrounds.¹³ Moreover, a national census of third-year family medicine residents revealed that those who train at THCs were more likely to work in safety net clinics after the completion of their residency training.¹⁴ Compared to graduates of other programs, graduates of THC programs were much more likely to maintain a broader scope of practice, practice close to their training sites, and practice in rural areas.^{15,16} THCGME residents have provided more than 1.1 million hours of patient care in primary care settings to more than 800 000 patients, expanding access to care in medically underserved and rural settings.⁴ Clearly, despite funding uncertainty for more than a decade, the THCGME has helped address the primary care workforce shortages and will continue to do so, especially in underserved areas.

A 2022 study of HRSA-commissioned THCs conducted by George Washington University found that the national median of true training costs is \$210,000.^{17,18} If the THCGME reauthorization bill fails to include this kind of increase, some programs will be unable to continue, because the current \$160,000 per resident amount is unsustainable.³ HRSA anticipates requiring approximately \$157 million to support 1469 resident full-time equivalents (FTEs) in the 2024-2025 academic year.⁴ This pales in comparison to the budget of total Medicare GME, which was estimated to be \$10.3 billion by the U.S. Government Accountability Office in fiscal

year (FY) 2015 for the support of 87 980 FTEs.¹⁹ In FY 2022, HRSA also funded 46 planning and development awards with resources from the American Rescue Plan Act under the Teaching Health Center Planning and Development Program (Public Health Service Act Section 749A). These grants provide start-up funding for new community-based primary care residency programs. In FY 2023, HRSA funded an additional 46 planning and development grants beginning in April 2023.²⁰ A notable recent prospect for the expansion of the THCGME program was The Build Back Better Act (H.R.5376), proposed on August 3, 2021,²¹ which appropriated \$3.37 billion to HRSA for the THCGME to remain available until expended. However, the bill stalled in the Senate in December 2021 and was ultimately blocked despite plans for additional amendments and Senate rule changes. Its subsequent form, The Inflation Reduction Act of 2022 (H.R.5376), passed on August 8, 2022, but did not provide funding to expand the THCGME.²¹ Prospects for standalone bills to fund the THCGMEs have since arisen.

Future Legislative Prospects

The most comprehensive of these candidate bills, the Doctors of Community Act (S.1958, H.R.2569), permanently authorizes the THCGME program to receive annual funding at approximately \$500 million and an increased annual number of residency spots over the FY 2024-FY 2033 interval. Limited action has been taken on this bill since June 2021, although it may be reintroduced this session by Senator Patty Murray (D-Washington) and was just introduced in the House by Representative Frank Pallone (D-New Jersey). Other champions in this space include Senator Susan M. Collins (R-Maine), Senator Jon Tester (D-Montana), Representative Raul Ruiz (D-California), and Representative Cathy McMorris Rodgers (R-Washington).²² Additional bills that aim to increase the workforce in underserved communities include the Resident Physician Shortage Reduction Act (S.1302, H.R.2389), Healthcare Workforce Resilience Act (S.1024), Conrad State 30 and Physician Access Reauthorization Act (S.665, H.R.3541), Resident Education Deferred Interest Act (S.704, H.R.1202), and the Ensuring Access to General Surgery Act (S.1140, H.R.1781). These bills constitute steps in the right direction and should be supported. But permanent funding of THCGME programs via a 10-year funding bill such as the Doctors of Community Act remains the most definitive mechanism for the long-term support of primary care training in underserved communities and has received explicit support from many organizations.^{23,24}

Efforts and support for sustained THCGME funding by the American Academy of Family Physicians,²⁵ American College of Physicians,²⁶ American College of Obstetricians and Gynecologists,³ Society of General Internal Medicine,³ Society of Teachers of Family Medicine,²⁷ Council of Academic Family Medicine,²⁷ American Association of Teaching Health Centers,²⁵ American Association of Colleges of Osteopathic Medicine,²⁸ American Osteopathic Association,²⁹ Advisory Committee on Training in Primary Care Medicine and Dentistry,³⁰ Council on Graduate Medical Education,²⁴ National Association of Community Health Centers,²⁵ and the American Association of Medical Colleges³¹ have been crucial in ensuring that THCGME funding remains a legislative priority. The medical community at large, not just primary care and rural area physicians, must engage with these organizations and their congressional representatives to share their stories, name specific bills that require support, and join in advocacy efforts by their specialty organizations.³² Physicians of all specialties must spur their respective specialty organizations to lend their support. Continuing engagement by educators and researchers is needed to grow the evidence base regarding the negative effects of THCGME funding uncertainty on training and patients.

Beyond advocacy, which is most time-sensitive, there are promising opportunities for programs to build coalitions across programs and health centers with a shared vision of community-based care and enhanced resident education. Most notable is the Accreditation Council for Graduate Medical Education-accredited Rural Track Program, in which residents and fellows gain both urban and rural experience during their training while facilitating the development of GME in underserved areas.³³ A shining example in this space is the Wright Center, the nation's largest HRSA-funded GME Safety-Net consortium.³⁴

It is likely that the THCGME will continue to confront funding uncertainty, a threat exacerbated by the substantial financial losses caused by the COVID-19 pandemic³⁵ and an ever-present shortage of primary care physicians. Both Congressional parties have recognized the importance of the THCGME program and have provided it with short-term funding extensions, despite budgetary strain caused by the COVID-19 pandemic.⁴ But THCGME funding will run out in September 2023.³ It is incumbent on all stakeholders to engage with legislators directly and through the networks established for over a decade by organizations dedicated to sustained primary care training in underserved communities. The time to advocate for the permanent funding of the THCGME program is now.

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