NATIONAL ASSOCIATION OF Community Health Centers

July 15, 2025

Thomas Engels
Administrator
Health Resources and Services Administration
Department of Health and Human Services
5600 Fishers Lane
Rockville, MD 20857

RE: The Teaching Health Center Graduate Medical Education Program Reconciliation Tool, (Attn: OMB No. 0915-0342-Revision)

Dear Administrator Engels:

The National Association of Community Health Centers (NACHC) is the leading national membership organization dedicated to promoting Community Health Centers (CHCs) (also known as Federally Qualified Health Centers or health centers) as the Employer, Provider, and Partner of choice in all communities, as well as the foundation of the primary health care system in America.

As you know, Community Health Centers are the best, most innovative, and resilient part of our nation's health system. For sixty years, health centers have provided high-quality, comprehensive, affordable primary and preventive care. In addition to medical services, CHCs provide dental, behavioral health, pharmacy, vision, and other essential health services to America's most vulnerable, medically underserved communities in urban, rural, suburban, frontier, mountain, and island communities. Today, health centers serve more than 32.5 million people at over 16,000 locations, ensuring patients receive the care they need and pay what they can based on a sliding fee scale.

NACHC maintains its role as the national voice for health centers and believes that high-quality primary health care is essential in creating healthy communities and preventing chronic conditions. The collective mission and mandate of NACHC and the 1,496 health centers nationwide are to close the primary care gap and provide access to high-quality, cost-effective primary and preventive medical care.

The 90 Teaching Health Centers (THCs), serving over 1,200 residents in 26 states and Washington, D.C.,[1] are an essential piece in the health center puzzle. Since its creation in 2010, the Teaching Health Center Graduate Medical Education (THCGME) program has allowed CHCs to improve workforce shortages and health outcomes. The THCGME program shifts the physician training paradigm and provides the majority of training at CHCs in community-based settings with a focus on rural and underserved communities. The need for this program remains true 15 years later, as CHCs continue to face workforce shortages, resulting in longer wait times, reduced hours of operation, and decreased appointment availability.

[1] www.bhw.hrsa.gov

We look forward to the opportunity to respond to this Information Collection Request (ICR) regarding the THCGME Reconciliation Tool to highlight the importance of data collection and accuracy of THCs and their GME slots, while continuing to identify ways to improve the program. Beyond the reconciliation data, accurate data about FTEs and the structure of THCGME programs ensures that the information collected for this reconciliation tool is clear, useful, and high-quality.

THCGME is a valuable program, and HRSA should continue to collect accurate data to ensure its success. The reconciliation tool is crucial for informing HRSA of the number of slots that need to be supported in a given year, whether any provided funding could be utilized more effectively, and whether funding and slots need to be increased at existing health centers or extended to other health centers. NACHC appreciates HRSA's sustained efforts in accurate data collection to support the program.

NACHC continues to advocate for the 54 Full Time Equivalents (FTEs) at CHCs that have been conditionally approved to receive funding and be considered in data collection. The 54 conditionally approved FTEs at 18 newly accredited training programs[2] that are already training residents starting this July should be counted for THCGME considerations. These FTEs fulfill all the requirements and should count as part of the program. THCGME is the only federally funded GME program with accountability metrics and reporting requirements for trainee outcomes. Yet, it faces uncertainty and delays in funding and slots that hinder the program's full success. Including the 54 conditionally approved FTEs will ensure adequate funding and support the THCGME program as a whole.

HRSA should continue to support the family medicine programs at THCs that provide a fourth year of training to address key community needs, such as maternal health. While not common, some THCs utilize an additional year of training as opposed to the traditional three-year residency program. The fourth year enables THCs to provide targeted training on relevant and timely topics, such as maternal care or infectious diseases, allowing the training to be tailored to the community's needs. NACHC encourages HRSA to collect accurate information on these programs to ensure they continue to receive the necessary resources to support their communities. For example, a THC family medicine program in New England utilizes a HRSA-approved four-year residency program. The program boasts impressive outcomes: 80 percent of its graduates work in underserved areas and 97 percent of graduates are satisfied with their training, compared to the national average of 89 percent. If funding for that fourth year were to be rescinded, the THC would lose nearly $600,000, causing the THC to reconsider its training model, particularly impacting its prenatal and obstetric training and care.

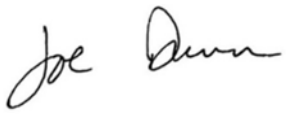
NACHC encourages HRSA to ensure that the reconciliation of duplicative payments does not reduce the payment to THCs unnecessarily and recommends that, in the event of a duplicative payment, the THCGME payment to a THC be reduced only by the actual amount of duplicative payment. NACHC appreciates HRSA's continued efforts to ensure that duplicative payments are not made within the Graduate Medical Education programs. However, we have concerns that the current methodology causes some THCGME programs to receive significantly less funding than they expected. For example, we have heard of THC residency programs facing

[2] As reported by those health centers

problems when their resident participates in a required inpatient rotation at a partner teaching hospital. If a duplicative payment is determined through the HRSA reconciliation to have occurred, the current practice is to reduce the THCGME payment to the THC by the resident's FTE amount that the resident rotated at the partner teaching hospital, multiplied by the THCGME per-resident payment of $160,000. This approach is disadvantageous to the THC. THCGME payments are currently $160,000 per resident FTE per year, while the average DGME payment to a teaching hospital is $55,000 per resident per year. This approach, therefore, results in THCGME payment reductions of nearly three times the amount of the actual duplicative DGME payment, creating additional administrative burdens on health centers to make up the funding loss from their projected payments. In the event of a duplicative payment, NACHC recommends that the THCGME payment to a THC be reduced only by the actual amount of the duplicative payment, which, in the case of the DGME payment, could be calculated by the teaching hospital's Medicare Cost Report, ensuring that the THC still receives sufficient payment.

NACHC appreciates the opportunity to respond to this ICR and looks forward to continuing to engage with HRSA on this prominent issue. Health centers are eager to collaborate with HRSA to implement improvements to the THCGME data collection and payment process. NACHC appreciates HRSA's continued investment in a successful National Training and Technical Assistance Partner (NTTAP), and we hope to work with HRSA and the NTTAP to support health centers in providing high-quality data. If you have any questions, please contact Elizabeth Linderbaum, Deputy Director of Regulatory Affairs, at elinderbaum@nachc.org.

Sincerely,



Joe Dunn
Chief Policy Officer