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February 5, 2015

Mari Cantwell, Chief Deputy Director  
California Department of Health Care Services  
P.O. Box 997413, MS 0000  
Sacramento, CA 95899-7413

Dear Ms. Cantwell,

I am writing today on behalf of California's Teaching Health Center Graduate Medical Education Program (THCGME) grantees, to strongly encourage you to prioritize "Option 6: Increase Residency Training Slots" and the sustaining and expansion of teaching health center residency slots.

Health centers in 24 states, including California, took advantage of the ACA's investment in primary care training through the THCGME program. California's six THCGME awardees are providing training to dozens of residents that are not only committed to primary care practice but also to serving underserved communities and health shortage areas. From Shasta County in California's Rural North to programs in San Diego and the Central Valley, our THCGME sites have quickly established themselves as gateways to community-based practice.

Investing in teaching health centers (THC) is not only an investment in new providers, but also provides immediate relief in shortage areas as residents provide direct patient care as part of their training.

According to a 2009 study, THC have produced residents that are nearly three times more likely to practice in underserved settings and are 3.4 times as likely to work in a health center (Morris et al.).

Important to providing care in underserved communities, THCGME programs are attracting medical school graduates who are from their communities and represent the cultural and linguistic diversity of their patients. Current THCGME sites in California have seen over 200 applicants per slot across the state. This year, THCGME sites in the Central Valley reported over 700 applicants to their programs.

While the ACA made a valuable investment in THC, now is the time for California, through the 1115 waiver, to take a stand to make sure this investment is not lost.

California THCGME grantees look to be a resource and partner to the current 1115 waiver conversation on increasing residency training slots in California. To this end, as the state prepares its initial proposal to CMS, our THCGME would like to take a moment to provide you with some initial comments, clarifications, and reflections on Option 6 of the UCSF report, presented to the Workforce Expert Stakeholder Workgroup at the January 7, 2015 meeting.

## **Option**

We strongly support use of the 1115 waiver fund to sustain and expand residency training slots, but strongly recommend that, in addition to the fund targeting mentioned, the following be considered as funds are targeted: (1) Counties where Primary Care HPSAs represent more than 50% of the area of that county should be given priority and (2) Programs that are producing graduates that are representative of the needs of the community they will be serving. This goes beyond considerations of racial/ethnic diversity, to include recognition of “rural” attributes. For example, in the Rural North, it is important we are producing candidates that understand and appreciate rural culture and rural life. Also, of note, if we simply target funding towards programs that are “racially/ethnically” diverse we risk unintentionally excluding teaching sites that are in regions of the state suffering from a significant shortage of primary care providers. Research by UCSF as well as California Health Care Foundation highlight well that, by region, provider shortages vary significantly. These regional differences should be taken into consideration.

We are excited to see specific reference under this option for the six teaching health centers that will lose federal funding soon. Please note, these teaching health centers are at risk of losing federal funding in 2015, not 2016. Additionally, it is important to note that the eight primary care residency programs that receive federal grants to fund existing slots to their historic minimum levels will be partially underfunded in 2015.

We support providing start-up funds for new residency programs in geographic areas and/or specialties in which Medi-Cal has the greatest need to recruit additional physicians. To encourage new residency programs, the department may want to consider modest “planning” grants in targeted underserved regions to help with the complex, and costly, process of establishing a new primary care residency program (including meeting ACGME accreditation standards). Such funding could also be used to support innovative models such as “consortium” approaches that bring together hospitals, health centers, and other community-based health entities to create a robust training program that meets community need (this model may be of particular interest in rural communities where one entity might be too small to support a residency program and where providers are more likely to work in both community-based and hospital settings).

Lastly, while we appreciate a number of the distribution mechanisms outlined, we strongly support the strategy of providing payments directly to community health centers, hospitals, or other health care organizations that operate residency programs and strongly oppose teaching health centers funds being distributed through the health plans.

## **Rationale**

We agree with evidence of need and evidence of effectiveness listed under the Rationale section of Option 6. With regards to effectiveness, it is important to note the immediate gains to patient care that come with such an investment. Investing in teaching health centers (THC) is not only an investment in new providers, but also provides immediate relief in shortage areas as residents provide direct patient care as part of their training.

## **DHCS Considerations for Prioritizing Options**

We appreciate the Department's outlining of the investment's potential savings, ability to leverage existing infrastructure, sustainability over time, ability to meet beneficiary need in the short-term, and measurability of investment.

## **Costs**

We appreciate the Department's outlining of costs, but do want to provide some clarifications on your understanding of THC costs, especially as it relates to Medicare GME costs. The Teaching Health Center Program uses \$150,000 per resident as the baseline level of support for the THC funded positions. It is important to note, that the Medicare GME formula does not marry well with

Community Health Center sponsored programs as Medicare patients are not a large percentage of CHC patient mix and the Medicare GME formula is based on the Medicare patient volume. For this reason, the current THC program was designed to move away from the Medicare bias, as well as hospital focus of the Medicare GME program.

As the Department considers how to best "stretch" 1115 waiver funds across a larger number of residency programs that are more geographically diverse, that are representative of the needs of our urban and rural communities, we urge you to help sustain and expand existing residency programs, such as our states 6 teaching health centers. As we consider support for new sites, it is critically important that we remember that research indicates that 70% of residents choose to work and practice within 100 miles of where they are trained. Lastly, as primary care residencies are three year commitments, funding must also be committed to cover the full three years of that cohorts training.

If you or your staff would like additional information, please feel free to contact me as I am happy to work with California Primary Care Association to connect you with our THCGME grantees.

Regards,

A handwritten signature in blue ink, appearing to read "Jim Mangia".

Jim Mangia, MPH  
President & CEO

cc's: Mari Cantwell, DHCS  
Wendy Soe, Policy Specialist, DHCS  
Anastasia Dodson, DHCS  
Bobbie Wunsch, Pacific Health Consulting Group