COGME Council on Graduate Medical Education

Meeting Minutes: September 12, 2024

The Council on Graduate Medical Education (COGME or Council) held a meeting on September 12, 2024. The meeting was hosted by the Bureau of Health Workforce (BHW), Health Resources and Services Administration (HRSA), Department of Health and Human Services (HHS), and conducted via a videoconference platform. In accordance with the provisions of the Federal Advisory Committee Act (Public Law 92–463), the meeting was open to the public for its duration.

Council Members in Attendance

Appointed Members

Peter Hollmann, MD, Chair
Erin Fraher, PhD, MPP
Andrew Bazemore, MD, MPH
Warren Jones, MD
Byron Joyner, MD
John Norcini, MD
Linda Thomas-Hemak, MD
Surendra Varma, MD, DSc (Hon)
Kenneth Veit, DO, MBA

Federal Representatives

Joseph Brooks (Designee: Centers for Medicare and Medicaid Services)
John Byrne, DO (Designee: Department of Veterans Affairs)
Joan Weiss, PhD, RN (Designee: Health Resources and Services Administration)
Leith States, MD, MPH (Designee: Assistant Secretary for Health)

Health Resources and Services Administration Staff Present:

Shane Rogers, Designated Federal Officer, COGME
Raymond Bingham, MSN, Writer and Editor, Division of Medicine and Dentistry, HRSA
Janet Robinson, Workforce Administration Team, BHW, HRSA

Welcome and Introductions

Mr. Shane Rogers, the Designated Federal Officer for COGME, convened the Council's second meeting of fiscal year 2024 at 10:00 a.m. ET. Mr. Rogers turned the meeting over to the COGME chair, Dr. Peter Hollmann. Dr. Hollmann conducted a roll call, indicating the attendance of 13 of the Council's 14 members and confirming the presence of a quorum. One member had an excused absence. Dr. Hollmann introduced the first speaker.

Presentation: Bureau of Health Workforce Updates

Candice Chen, M.D., M.P.H.
Acting Associate Administrator for the Bureau of Health Workforce, HRSA

Dr. Candice Chen, Acting Associate Administrator for the Bureau of Health Workforce, HRSA, reviewed recent workforce projections from the National Center for Health Workforce Analysis, highlighting the projected shortages over the next 12 years of registered nurses and licensed practical nurses (only 90 percent of projected need), primary care physicians (81 percent of projected need), and behavioral health providers (70 percent of projected need). Dr. Chen

stressed that addressing regulatory and reimbursement barriers and promoting team-based care (TBC) could result in better distribution and utilization of the workforce.

Dr. Chen provided a general overview of current BHW health workforce programs, noting the goal of preparing a health workforce able to serve communities of need. She listed some of the BHW Strategies for Success: recruit students from local communities; provide training in rural and underserved communities and in community-based settings; provide loan and scholarship opportunities; train students in interprofessional, collaborative team environments; and integrate behavioral and public health into primary care. HRSA and BHW focus areas for the upcoming year include mental and behavioral health, health equity, community health, and maternal health, with cross-cutting themes of improving workforce diversity, promoting workforce distribution to areas of need, and supporting provider resilience. She also discussed the proposed 2025 budget, highlighting two key items up for reauthorization: the National Health Service Corps and the Teaching Health Centers Graduate Medical Education (THCGME) program.

Dr. Chen reviewed select BHW investments in primary care, with an emphasis on two HRSA programs: the Geriatric Workforce Enhancement Program, which helps train physicians and physician assistants, nurses, and behavioral health providers to develop the workforce needed to care for older adults, and funding provided to state-level primary care offices to improve data collection and sharing, with particular emphasis on the HRSA-identified health professional shortage areas. She also informed the Council members of the upcoming HRSA Primary Care Residency Fair, a virtual event to connect students with opportunities in primary care, with a focus on the THCGME program.

Q and A

There was a comment about the consistent support that COGME has expressed for long-term, sustainable funding of the THCGME program, citing its success as an example of social accountability for graduate medical education (GME) funding. Noting that many HRSA programs are siloed by profession, there was a question about the ability of HRSA to prioritize programs, such as THCGME and the Geriatrics Workforce Enhancement Program, that promote interprofessional teams. Dr. Chen replied that HRSA supports TBC, adding that Congress had proposed funding for a health workforce innovation program that would give communities the flexibility to train the workforce that they need. She noted that the inconsistent funding of the THCGME program could impede its growth, but it also provided an opportunity to educate the members of Congress on its value.

There was a comment about the HRSA programs on resilience of the workforce. Within the primary care environment, it was noted that the language is moving beyond resilience of the individual worker to place more emphasis on wellness within the healthcare system and developing leaders who can help workers thrive while managing trauma. Dr. Chen referred to a recent HRSA meeting with midwifery students on the challenges of maternal health care, during which many students commented that people are attracted to health care professions because of the mission to serve others and their desire to help fix the problems.

There was a question about how COGME could best promote GME investments in improving the physician workforce. Dr. Chen replied that she was encouraged by recent interest from Congress in improving the efficacy of GME funding.

Discussion: Draft COGME 25th Report

Moderator: Peter Hollmann, M.D.
Chair, COGME

Morning Discussion

Dr. Hollmann moderated discussion sessions to review a draft outline and some initial draft text and recommendations proposed for the Council's 25th Report. He noted that the report addresses TBC as a response to the rising demands on the healthcare workforce. The report would not provide a comprehensive overview of TBC, but rather to focus on ways to implement TBC models to mitigate workforce shortages, support alternative payment systems, promote the integration of behavioral health services into primary care, and enhance the value of teamwork in improving the wellness and reducing the moral injury and burnout of providers.

There was a comment that different models of TBC had been discussed for many years, but momentum was building from health care payors such as Medicare, as well as federal health workforce programs and educational accreditation agencies. As a result, the COGME report could serve as an accelerant to move the discussions forward on ways to embed TBC across all areas of health professions education and practice. COGME would also need to recognize that teams are dynamic, and their composition can differ across different communities and microsystems. There was another comment that teams work best when they contain individuals from diverse backgrounds and a range of professions. Diversity also helps in serving minority populations and engaging community participation. There was another comment on the need for teams to incorporate mental health counseling for physicians and other providers.

Dr. Hollmann added that the report will have to provide a clear definition of TBC, as well as to discuss barriers that had prevented previous initiatives from moving forward. In previous meetings, COGME members had noted that teams should include members from at least two different professions, and preferably three or more. Teams should also include all those involved in the care of a patient, without regard to any specific degree or licensure. Thus, the teams could include care navigators, health coaches, and other types of paraprofessional providers. The primary focus was to build the team around the needs of the patient or the local community.

Dr. Hollmann moved the discussion to examine the draft recommendations, starting with a proposal to recommend that ten percent of federal GME funding, which may include funding from Medicare, HRSA, or the Veterans Administration (VA), be directed toward training programs that include two or more healthcare professional schools. The intent was to include multiple training sites involving two or more professions and education institutions, with the expectation to include acute care hospitals but also community health settings.

There was a concern expressed about how to define "multiple training sites." While the term appears to cover a range of setting to include inpatient, outpatient, rural, and urban areas, some institutions may interpret the recommendation to allow them to shift students among different sites within their systems. The language of the recommendation may need to state more specifically the need to include a diverse set of training sites.

There was a question about whether federally qualified health centers (FQHCs) were included as

training sites under this recommendation. Dr. Hollmann stated that governing boards of FQHCs must have at least 50 percent representation from the local community, similar to many not-for-profit community hospitals. There was an additional comment that Community Health Centers (CHCs), many of which serve as Teaching Health Centers within the THCGME program, must have voting representatives from the local community in their governance structure, so that they are governed by people from the community and the consumers of its services.

There was a concern expressed that health centers under the VA might face conflicts, as the VA can only cover care for veterans provided at VA facilities. For VA clinics to be eligible under this recommendation or to become involved with FQHCs would require a legislative change in its funding mechanisms.

Dr. Hollmann moved the discussion to the next recommendation, to increase funding for HRSA's Preventive Medicine Residency (PMR) program to train residents and other team members in population health and in measuring population health outcomes. The intent of this recommendation was to enhance public health knowledge and have the public health community become part of the healthcare team. He noted that HRSA had direct control over the PMR residency funding, while most GME funding is controlled by other agencies, primarily the Centers for Medicare and Medicaid Services (CMS).

There was a comment that this recommendation falls under the COGME charge for programs authorized under Title VII of the Public Health Service Act. The recommendation could help the PMR program align with other public health solutions that call forth the need for teams. There was another comment about HRSA's efforts to integrate the PMR program in FQHCs. It was further noted that the areas of public health and population health deal with multiple professions, including medicine, nursing, behavioral health, and oral health, and well as data analytics.

Dr. Hollmann moved on to discuss a recommendation that HRSA, or another HHS agency, provide grant funding to state-level primary care associations to coordinate with the Department of Labor (DOL) and other sources to promote interprofessional education. He noted that primary care practices need a broad staff that includes medical personnel and support staff, but they often struggle to find enough workers. There was a caution raised that this recommendation could reach beyond the scope of COGME and involve other programs that are overseen by other federal advisory committees. There was some follow-up discussion on the ability of these committees to coordinate with and reinforce each other to avoid direct contradictions.

There was a brief discussion on a proposed COGME recommendation to increase funding for the successful interprofessional education model of HRSA's Area Health Education Centers (AHECs). It was noted that the AHEC program falls under the purview of another federal advisory committee, and COGME has no direct charge to recommend funding levels. There was a comment that some states have created incentives to link federal funding for AHECs with state, local, and private funding. Without this support, the AHECs tend to wither from lack of sufficient funding to meet their mission.

Dr. Hollmann moved on to the proposed recommendation to increase the number of residency slots for the THCGME program and to fund the THCGME Development Program to have a

focus on interprofessional education (IPE), TBC, and community-based linkages. He reiterated the Council's past support for THCGME funding, and noted Dr. Chen's earlier comment regarding the reauthorization of the program.

There was a comment that the Accreditation Council for Graduate Medical Education has an accreditation requirement that GME programs train residents in TBC. However, there was further discussion on surveys that have indicated residents often fail to learn TBC skills or practice in interprofessional teams. The TBC requirements may be viewed as no more than a "check-off" on the accreditation requirements without any real enforcement. Another Council member referred to the airline industry, in which flight attendants from different crews are trained to work with each other on a routine flight, as well as how to act in dangerous situations. It was further noted that simulation exercises can help with teaching the concepts of teaming.

Dr. Hollmann reviewed the next recommendation to require HHS and the DOL to develop a coordinated strategy for interprofessional health workforce development, to include the distribution of grant funds under the Workforce Innovation and Opportunity Act (WIOA). He noted that this recommendation was similar to a previous recommendation to provide health workforce grants to organizations at state level, and also questioned how many people understood the details of the WIOA.

There was a comment that the DOL examines new jobs coming into the market, including roles such as community health workers and certified recovery specialists. AHECs in particular often embrace these types of jobs programs to improve recruitment and provide economic mobility to members of the local communities they serve. Many AHECs and other community health centers see a benefit in improved workforce pipelines that can connect workers to available positions, broaden the reach of health care teams, and expand the capacity of health care providers to deliver care.

Lastly, Dr. Hollmann raised another a potential recommendation about the creation of academic career awards for a new type of fellowship in IPE. The idea would be to develop IPE as an academic area of expertise for health care professionals. Applicants would come from many professional backgrounds, and the fellowship training would focus on team-building, communication, and shared training and responsibility. These fellows would the be able to "train the trainers" in each one of their institutions and build interprofessional health care teams. He added that two or more different health professions schools might apply jointly for the award.

Afternoon Discussion

In the afternoon, Dr. Hollmann returned to the discussion of the 25th Report to cover several proposed recommendations to CMS. He noted that although the recommendations are intended for CMS as the major funding agency for GME, the wording is addressed to Congress in its oversight capacity. In previous discussions, it had been decided that CMS is outside of the direct purview of COGME, thus the recommendations would be stronger in asking Congress to direct CMS to implement the recommended steps.

The first recommendation concerned funding of a Graduate Nurse Education (GNE) program, along the lines of GME funding. However, the point was raised that GNE had been a 4-year

pilot program that was discontinued in 2016. There was some further discussion of making a collaborative effort with the National Advisory Council on Nurse Education and Practice (NACNEP), if there was interest in reviving and advancing this program.

The next recommendation addressed a revision to the Medicare Physician Fee Schedule to support IPE and TBC through the establishment of billing codes for IPE sites, new billing codes to cover services from pharmacists and other providers, and increased payments to nurse practitioners and physician assistants to recognize their role in delivering high-quality care. One Council member cautioned that the wording of the recommendation would need to be specific, as it could create the opportunity for double payments from federal agencies covering workforce development dollars and care delivery dollars, which is not the Council's intent.

The next recommendation addressed enhancements to the Medicare Shared Saving Program (MSSP), Center for Medicare and Medicaid Innovation (CMMI), and Medicare Advantage programs to focus on TBC. The first point was to have MSSP develop and implement quality metrics that measure the effectiveness and integration of care teams, along with the involvement of patient advisory committees. The next point recommended funding an MSSP support center, along the lines of other CMMI projects, to provide assistance and information and to disseminate best practices. The last point would mandate that Medicare Advantage plans adhere to the physician fee schedule rules to support for TBC within their networks.

Lastly, there was a recommendation to encourage CMS to establish and fund learning collaboratives that enable states to share and adopt best practices for utilizing Medicaid funds and state appropriations to enhance IPE and support TBC. There was a further point to link funding to explicit criteria to meet population health needs, close healthcare gaps, and prepare for future public health challenges. In addition, there was a recommendation to mandate that states receiving 1115B waivers, which authorize the HHS Secretary to approve experimental or demonstration projects that promote the objectives of CMS, be required to collect and report detailed information on how these funds are allocated towards the development and support of interprofessional training programs.

Dr. Hollmann added that the report should include examples of successful models to highlight actions needed to sustain team-based models of care and emphasize the message that steps to improve IPE and TBC can have a positive impact on patient care, the healthcare environment, and the wellbeing of healthcare providers.

Dr. Hollmann reviewed a list of some of the barriers to TBC that had been raised in previous discussions, noting that the list was not intended to be comprehensive but rather to highlight some of the longstanding impediments that have hindered prior efforts at establishing TBC:

- Federal GME funding is directed to hospitals to address the costs of training physicians. It is relatively inflexible and has not produced the workforce needed for the country.
- There is an insufficient educator workforce with expertise in IPE and TBC.
- Medicare payments for outpatient care are directed to individual physicians or hospital outpatient departments, which do not include practice costs of TBC or training.

- Medicare relies upon each participating organization to develop the knowledge and skills surrounding IPE/TBC on their own.
- Present HRSA grant funding mechanisms do not prioritize IPE/TBC.

Dr. Hollmann urged the COGME members to review the list to determine which of these were the highest priority, or if other common barriers should be included.

Dr. Hollmann also reviewed the list of TBC principles from previous COGME discussions:

- The creation and sustenance of teams must be intentional in both education and practice.
- Sustaining teams requires continued efforts in effective communication, roles and responsibilities, and process improvement.
- Effective teams utilize the right leader for the right task at the right time. No professional should claim a role that does not best fit the team in service to the patient.
- The team structure and composition is specific to the task of the team as required to provide optimal care and must be adaptable to changing circumstances and needs.
- Teams serve as a fundamental tool in righting the racial, ethnic, and cultural imbalance in our healthcare system.
- Teams should include members of the community and population served.
- Education and training should be focused on improving community health outcomes.
- Workforce projections should include assessments based upon the needs and potential efficiencies of TBC.
- Training depends upon clinical care delivery sites that can model TBC.
- Clinical delivery sites must be structured and financially supported in TBC.

There was further discussion on the need to define metrics of success about both the process of teaming and the patient and community health outcomes, as well as measures of provider satisfaction, retention, and wellness.

Conclusion

The Council voted to approve ongoing work on the 25th Report, with recommendations centered around the following themes: GME training standards for TBC, HRSA programs related to interprofessional education, and federal funding to enhance TBC through Medicare GME payments and Medicaid initiatives. The report draft and recommendations will undergo further review and refinement through the COGME writing group, in anticipation of preparing an updated draft ahead of the April 2025 COGME meeting.

Discussion: Federal GME Reports and Letter to the Senate Finance Committee

Moderator: Peter Hollmann, M.D.
Chair, COGME

Dr. Hollmann introduced the next agenda item by stating the Council would hold a discussion focused on two topics: 1) a review of a recent Government Accountability Office (GAO) report on GME, and some of its predecessors, and 2), a possible response from COGME to a Request

for Information (RFI) from the Senate Finance Committee (SFC) related to GME. On the second topic, Dr. Hollmann noted that the response period for the RFI had expired. However, Section 4 of the RFI document included a recommendation regarding the establishment of a GME Policy Council and contained some content specific to COGME. Thus, the Council may wish to respond in the form of a letter to the HHS Secretary and Congress. He turned the floor over to Council member Dr. Andrew Bazemore for a short presentation.

Presentation: Federal GME Reports & 14 Years of Echoes

Dr. Bazemore opened his presentation by stating that there are situations in which the reports and recommendations from an advisory council like COGME, as well as from other watchdog groups such as the GAO, begin to echo each other and become repetitive. This cycle raises the question about what impact the recommendations are having.

Dr. Bazemore shared a timeline denoting GME policy milestones going back to 1965, with the creation of Medicare and its funding of medical residency programs that was initially intended as a temporary fix. However, as federal funding for GME became more entrenched, groups such as Medicare Payment Advisory Commission (MedPAC), the advisory council for Medicare, and the National Academy of Medicine (NAM) began highlighting the lack of coordination of federal GME financing. A 2010 MedPAC report to Congress recommended that Medicare GME payments be more closely linked to the outcomes of residency training and called for the development of a national GME strategy to better align residency training with the health care needs of the nation. MedPAC noted that the federal government would need to assume a more active role in using GME financing to shape the physician workforce and address healthcare priorities. A 2014 report from NAM also noted the lack of coordination of federal GME funding and recommended reforms, including better data collection and increased accountability.

In 2017, a report from the GAO highlighted growing and persistent geographic imbalances in the physician workforce between urban and rural areas and different regions of the country, as well as a loss of general practitioners due to an increase in specialization. The GAO recommended federal efforts to promote training in primary care and to increase rural training. Also in 2017, COGME issued a report calling for the development of a national strategic plan for GME that would address the need for a more coordinated federal approach, improved GME data collection, and methods to mitigate the shortage of primary care physicians and the maldistribution of the physician workforce. Subsequent reports from the GAO and MedPAC reiterated these calls.

In a series of issue briefs and subsequent report on rural health care, COGME (2023) recommended federal funding for a comprehensive assessment of rural health needs and directed the HHS Secretary to develop a set of measures to examine the return on public investment in GME, along with mechanisms to link financial accountability to patient outcomes, population health, and the well-being and resilience of physicians and other health professionals.

Meanwhile, in response to the COVID-19 pandemic, Congress enacted the 2020 Coronavirus Aid, Relief, and Economic Security Act, which included a requirement for HHS to develop a coordinated health care workforce plan, with a specific reference for HHS to act in consultation with COGME and the Advisory Committee on Training in Primary Care Medicine and Dentistry. HHS completed this report, after receiving additional input from the Advisory Committee on Interdisciplinary, Community-Based Linkages and NACNEP.

Dr. Bazemore noted that these various reports and other efforts have consistently emphasized the need to align federal GME funding with national health care priorities through the development of a national physician and health care workforce strategic plan, along with the need to improve transparency, data collection, and coordination. To date though, little has been accomplished to address these recommendations.

Dr. Bazemore raised the issue of a recent call from the SFC Bipartisan Medicare Working Group to take several steps to improve GME data collection and reporting, with the goal to ensure that federal investments align with addressing physician shortages, particularly in rural and other underserved areas, along with the creation of a GME Policy Council that could:

- Develop and oversee a strategic plan for Medicare GME financing to meet changing population health needs.
- Conduct research and policy development regarding the sufficiency, geographic distribution, and specialty configuration of the physician workforce.
- Develop metrics to track GME outcomes.
- Recommend federal policies on the distribution and use of Medicare GME funds.
- Promote collaboration among private and public entities including health systems, community health centers, private accreditation and certification organizations.
- Provide an annual progress report to Congress on the state of GME.

General Discussion

Dr. Hollmann shared with the Council the text of Section 4 of the SFC RFI document. He noted provisions of this Section would direct the HHS Secretary to establish a nine-member, time-limited GME Policy Council that would make recommendations to the HHS Secretary regarding the distribution of the new GME slots to be added in rural areas and in certain medical specialties. He highlighted a question from this section that asks if COGME might "fulfill the goals of this new Medicare GME Policy Council?"

Dr. Hollmann stated that he believed COGME would need more information about the roles and function of the proposed new GME Policy Council before considering whether it could assume this role. He stated his opinion that, as currently constituted, COGME lacked the resources to assume this new charge.

There was a comment that the proposed new Council would need to be embedded within HHS, have access to data related to the reviewing and distribution of GME slots, and have the authority to coordinate with multiple the federal agencies to request and receive information to help in its analysis. It was noted that reviewing and implementing the distribution of new GME slots would involve lot of behind-the-curtain interactions that are beyond the scope of COGME.

There was another comment on the limitations of using federal funding of GME residency slots to influence the career directions of residents and ultimately reshape the physician workforce. Rapid changes in the health care delivery system are creating new roles and providing various financial incentives for medical graduates to leave primary care and enter new specialties. It was noted that more than eighty percent of residents go into a subspecialty after they graduate, and

only a limited number enter primary care or general internal medicine.

One Council member commented that HRSA had worked to bring the THCGME program in alignment with CMS, and audits of the THCGME financial outcomes were improving accountability. There was a suggestion to find ways to better articulate this progress, as well as to illuminate the role of COGME in supporting THCGME. There was also a comment that THCGME lacks a long-term data set to demonstrate its success, which has hampered legislative efforts to permanently fund the program.

Letter discussion

Dr. Hollmann conducted an initial straw poll on the proposal for COGME to prepare a letter to be submitted to the HHS Secretary and Congress in response to the SFC. The proposal was approved by unanimous consent.

There was a comment that the SFC document refers to having the GME Policy Council serve in a time-limited fashion to provide advice on adding new GME residency slots. However, previous efforts involving the addition of new slots involved significant lobbying from powerful groups. As noted in previous comments, efforts to tie GME funding to encouraging more residents to practice in rural or underserved areas or to enter primary care have had little success, and the GME enterprise as a whole has limited influence on the final decisions of where residents choose to practice or what specialties they enter. The letter should address value and accountability and suggest some mechanism of attaching funds to downstream proposals, but without the threat of a complete loss of funding. There was another comment that little will change unless programs that accept funding for new GME slots without making progress toward reforming the workforce face some risk of funding withdrawal.

Another commentor noted the need for a common set of metrics that unify all stakeholders, in order to generate a sense of shared purpose and accountability. There was further discussion on the need to incentivize programs to achieve the desired goals of encouraging more residents to enter primary care and practice in rural or other underserved regions.

One member stated that the role of a director of a family practice residency program was to develop physicians for primary care in communities and give them skill sets and attributes to be successful, not to influence where they choose to practice. State-level programs can set some service requirements for residents who accept grant or scholarship funding, but it would create problems to try to hold residency programs accountable for decisions made by the doctors they train. There was a related comment on the need to avoid unintended consequences in the design of programs to add new residency slots that may restrict the freedom of graduate physicians.

In summary, Dr. Hollmann proposed the response letter to the SFC should emphasize the following points:

- Reiterate previous calls from COGME for a national health workforce strategy and improved GME data collection.
- Emphasize shared responsibility for financial accountability.

- Support the creation of a GME Medicare Policy Council charged with GME funding oversight, with the recommendations that this council not be time limited, and that it be provided with adequate resources and have access to multi-agency data.
- Indicate that COGME in its current state is not adequately resourced to assume this charge, but should be involved in the creation and design of the council and review of its ongoing work.

After some brief further discussion and clarification, a motion was made and seconded to approve the drafting of the letter, and the motion passed by unanimous voice vote.

Discussion: Letter in support of CMS rules

Moderator: Peter Hollmann, M.D.
Chair, COGME

Dr. Hollmann proposed as a new business item that COGME draft a letter to the HHS Secretary and Congress in support of a change proposed under Medicare's 2025 Physician Fee Schedule to implement a new Advanced Primary Care Management (APCM) system that would simplify billing procedures for primary care practices and bolster TBC. Current procedures under Medicare often involve complicated sets of rules and requirements to bill for common primary care services such as health check-ups, chronic care management, and telephone or telehealth encounters. In place of the current system, the APCM proposal would create a series of codes to be reported monthly by a qualifying primary care practice for each patient based on three different levels of anticipated care: one or fewer chronic conditions; two more or chronic conditions; or two on more chronic conditions with a qualified Medicare beneficiary. The CMS rules clarify how practices can determine the levels of care for each of their eligible clients. The practices would then receive a monthly payment related to the level of care for each recipient.

Dr. Hollmann emphasized that this proposed change could become a landmark game changer in promoting administrative simplification for primary care practices and could stimulate more practitioners to work in advanced primary care. He shared his experience working in a primary care clinic under the CMS Comprehensive Primary Care Plus model. The practice had hired nurse care managers, pharmacists, and a social worker, among others, but CMS billing had not kept up. He suggested that COGME write a short letter to the HHS Secretary and Congress to express the Council's support, noting that the APCM payment methodology would advance the Council's objective of patient-centered, population-based interprofessional team care.

He noted that the proposed change also includes a requirement on quality reporting, adding that the reporting requirements had been streamlined, and most practices are already taking part in the CMS Merit-based Incentive Payment System (MIPS) or a related demonstration project and thus already meet the reporting requirements.

A Council member expressed concern that practices might not be able to bill for more advanced or complex services if they were using the proposed new codes. Dr. Hollmann replied that the new codes would apply only during months in which a base level of services were provided. If more advanced care was delivered for a particular patient, the practice could bill under the appropriate codes.

Another member stated that providers are not always aware of the relevant codes, and thus are not using them. There was some discussion of efforts to help more providers learn about the codes and how they apply to Medicare billing.

There was a motion made and seconded to approve the drafting of a letter in support of the APCM rule. The motion passed by unanimous voice vote.

Public Comment

The Council received one public comment. Karen Mitchell, M.D., Vice President of Student and Resident Initiatives at the American Academy of Family Physicians (AAFP), offered some feedback on the Council's proposed letter to the SFC. Mitchell stated that the AAFP supports the creation of the GME Medicare Policy Council. If formed, AAFP believes that such a council must include representation from primary care physicians and from the THCGME program, given the importance of primary care in improving overall health outcomes in the country. Mitchell further noted two AAFP policies that were relevant to the COGME discussions: one in support of improving accountability in federal GME payments to correct the historical maldistribution of funding by geographic and specialty areas, and the other to replace the direct and indirect GME funding with a per resident payment along with a relaxing of the GME caps on primary care residencies, particularly in programs that serve health professional shortage areas.

Business Meeting

Mr. Rogers reminded the members that the next COGME meeting will take place in-person at the HRSA headquarters, with a virtual platform available, and is scheduled for April 10-11, 2025. He added that he had submitted the COGME charter renewal, and it should be finalized in the coming weeks.

Mr. Rogers informed the Council that the terms of five current members would end as of September 30, 2024. In addition, the terms of five other members would end within the upcoming year, while the terms of three current members had been extended. He stated that three new members of COGME had been approved by the HHS Secretary, however their final clearance had not been completed in time for them to attend the current meeting. He added that a package of four nominees had been submitted and was under review, with hopes of approval ahead of the next COGME meeting. In addition, another package of nominees was being prepared for submission to fill all anticipated vacancies.

Mr. Rogers adjourned the meeting at 5:00 p.m. ET.

Acronym and Abbreviation List

AAFP	American Academy of Family Physicians
AHEC	Area Health Education Center
APCM	Advanced Primary Care Management
BHW	Bureau of Health Workforce
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare and Medicaid Services
COGME	Council on Graduate Medical Education
DOL	Department of Labor
FQHC	Federally Qualified Health Center
GAO	Government Accountability Office
GME	Graduate Medical Education
GNE	Graduate Nursing Education
HHS	U.S. Department of Health and Human Services
HRSA	Health Resources and Services Administration
IPE	Interprofessional Education
MedPAC	Medicare Payment Advisory Commission
MSSP	Medicare Shared Saving Program
NACNEP	National Advisory Council on Nurse Education and Practice
NAM	National Academy of Medicine
PMR	Preventive Medicine Residency
RFI	Request for Information
SFC	Senate Finance Committee
TBC	Team-Based Care
THCGME	Teaching Health Center Graduate Medical Education
VA	Veterans Administration
WIOA	Workforce Innovation and Opportunity Act