COGME
Council on Graduate Medical Education

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Chair
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Designated Federal Official

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

Dear Secretary Becerra,

The Council on Graduate Medical Education (COGME) is grateful for the opportunity to contribute input to the Department of Health & Human Services (HHS) in the development of "a comprehensive and coordinated plan with respect to the health care workforce," as required under Section 3402 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act (Public Law No. 116-136). Developing such a plan is an essential step toward a more rational and effective workforce policy for our nation, especially in the face of the current COVID-19 pandemic.

We applaud the leadership of the Health Resources and Services Administration (HRSA) in developing a draft framework for the strategic plan. We suggest future iterations of this framework consider the following:

- Unlike most advanced economies, our country lacks a central authority to direct public investments toward the health workforce required to meet population health needs. COGME supports appropriating funds to support the National Health Workforce Commission, as authorized by the Affordable Care Act. The Commission will serve as a resource on health care workforce policy for Congress, the Administration, States, and localities. The Commission will play a critical, and much needed, leadership role in evaluating healthcare workforce needs, assessing education and training activities, identifying barriers to improved coordination at the Federal, State, and local levels and recommending changes to address those barriers and develop the health workforce this country needs now and in the future.
- The HRSA Strategic Planning framework that COGME reviewed in late 2020 reflected historic HHS workforce programs, but did not describe a path toward developing the health and social care workforce needed for the future. We suggest including language in the strategic plan that identifies how HHS will invest in developing this future workforce – both those in the pipeline and in current practice – to prepare for practice in interprofessional teams that provide integrated, whole-person care within value-based care payment models.
- There is a need for better coordination and alignment *between* the Centers for Medicare & Medicaid Services (CMS) and HRSA, as well as *within* HRSA programs. CMS is driving payment policy toward preventive care and population health, yet these changes have not had any significant effect on how the federal government invests in training and developing the primary care and public health workforce needed to provide value-based care.
- Furthermore, as the nation moves toward care delivery models that integrate primary care and behavioral health, increased coordination between HRSA and the Substance Abuse and Mental Health Services Administration (SAMHSA) will be critical.

- The CARES Act references "performance measures to determine the extent to which the HHS programs are strengthening the nation's health care system." To demonstrate return on investment, the strategic plan framework needs to include language that connects workforce funding to measurable outcomes. More specifically, workforce data are needed to target training investments and to evaluate the degree to which these investments are meeting:
    - Population health needs (including primary care, behavioral health, and maternal health care needs);
    - The nation's goals in addressing health equity and increasing the diversity of the health care workforce;
    - Changing workforce demands driven by alternative payment models; and
    - Delivery reform efforts being implemented by CMS.
- HHS will need to develop consistent and clearly defined metrics and outcomes for its workforce investments, including those in graduate medical education (GME) as well as in Title VII and Title VIII programs covering other health professions. The Children's Hospital GME Quality Bonus System and the Teaching Health Centers GME programs have begun to develop metrics and to link these outcomes to funding. This work needs to be expanded and scaled across all HHS workforce programs.
- The current framework refers to efforts to "increase supply" of health professionals. Given the rapidly changing demands of the health care system, COGME supports language that suggests that health workforce supply must be flexible and responsive to emerging health needs, changing models of care and reimbursement, and care delivery reform.
- The framework should capture that care delivery is shifting away from acute care to community- and home-based settings. The nation needs to target investments toward preparing the workforce to practice in this wide range of settings. For example, recent MedPAC discussions have identified the need to redistribute GME funding (with an overall budget neutral effect) to focus less on hospitals, and provide more support to:
    - Outpatient clinics – to include ambulatory, home, and virtual care; and
    - Practitioners and clinics using interprofessional team-based care and education.
- The "Improving Provider Quality" category might be better framed as "Improving Patient Outcomes" by building and maintaining competence throughout the health professionals' career – from initial education and training to retirement. This revised wording would reflect the need for ongoing, lifelong training to help providers keep abreast of changes in practice, new modes of care (e.g. telehealth which has expanded rapidly during the pandemic), and new delivery models. It could also include an explicit focus on supporting clinicians to promote workforce retention and prevent burnout.
- The "Promote Equitable Distribution" category should explicitly reference the HHS and HRSA missions of addressing *health disparities*. The language could reference the multiple dimensions of equity:
    - Geographic equity to meet the needs of rural, underserved, and vulnerable populations;
    - The need for diverse specialties and professions working in teams; and
    - Health practitioner diversity that is concordant with, and representative of, the populations served.

- Lastly, the plan must balance state and federal workforce planning efforts. Many workforce policy levers are controlled by states – from scope of practice regulations to state appropriations for health workforce training. A strategic plan that incorporates states as key partners in workforce development, data collection, and training, and as laboratories of innovation, might ease concerns about federal "overreach" in establishing a National Health Workforce Commission.

In summary, COGME strongly supports the development of a health workforce strategic plan. The Council further believes that payment incentives must be linked to workforce redesign to effect transformative, sustainable changes that achieve the strategic plan goals. Without significant changes in payment that support team-based training in ambulatory settings, HHS will not achieve the desired workforce and healthcare outcomes.

Sincerely,

/s/ Erin Patricia Fraher, PhD, MPP
Chair, COGME