Council of Academic Family Medicine

STFM Society of Teachers of Family Medicine | ADFM Association of Departments of Family Medicine | AFMRD Association of Family Medicine Residency Directors | NAPCRG

CAFM REPORT TO THE FAMILY MEDICINE LEADERSHIP CONSORTIUM (FMLC)
August 2025

CAFM has met twice since the FebruaryFMLC Meeting – in April and May. Below are updates from those meetings as well as some recent government relations updates. Over the past few months, the group has focused on refining strategic priorities, landing on AI, point-of-care ultrasound (POCUS), and research. However, the group has also focused its attention on recent Match data updates and an urgent need to prioritize pathway issues and the declining interest in family medicine (FM) and the recent AAFM workforce shortage report. Updates to the items mentioned are included in the following.

ONGOING WORK AROUND NEW STRATEGIC PLAN RELATED TO ARTIFICIAL INTELLIGENCE AND EDUCATION
As a reminder, the strategic goals for 2024 - 2025 for CAFM are:

Goal 1*: Organizational members support: CAFM will explore how to use AI to more effectively serve the needs of the CAFM organizations' members. Summary of action steps:*

1. *Monitor and surface innovative uses of AI in academic family medicine that may advance the outcomes of undergraduate and graduate medical education in family medicine*
2. *Develop guiding values*
3. *Create opportunities for peer sharing (among members)*

Goal 2*: Internal support: CAFM will explore how to shape and influence the responsible development and implementation of AI for the academic family medicine organizations' internal operations.*

1. *Create a list of materials and practices that are already in existence - e.g. who is using which AI tool and for what purpose?*
2. *Create opportunities for peer sharing (within organizations/staff) - what is working well for those who are using AI tools?*

During February's in person meeting, CAFM reviewed how institutions are addressing AI's integration and ethical use in academic family medicine and beyond. They used this review to inform a discussion around AI and education. The framing focused on the uses of AI, the challenges and concerns. The responses were used to create a draft set of guiding values in AI and education that CAFM will be finalizing during their August meeting.

2025 MATCH RATE RESULTS
In the spring of this year, new Match data signaled an urgent need for CAFM to prioritize pathway issues and the declining interest in family medicine (FM). The group discussed the issues and possible ways to address them in their April meeting and in May, Karen Michelle presented the AAFP initiative meant to

improve the residency selection process, highlighting challenges in filling family medicine positions and the need for an in-person convening in late August with stakeholders to address system inefficiencies. She mentioned that as part of this process, the group would consider various options, including changes to the application process, collaboration with the NRMP, or even moving outside the match system, while also addressing student choice issues. CAFM will remain engaged in this issue and see if there are any gaps that need to be filled beyond the summit the AAFP is putting together.

FM OB PLAYBOOK

ADFM, AFMRD, and AAFP OB Member Interest Group met at the end of January to continue the conversation about creating some sort of playbook for FM maternity care; this conversation led to a suggestion of CAFM to create a taskforce for this work.

This was largely spurred by what had occurred in fall 2024 at Boston Medical Center (BMC). The Family Medicine (FM) team was informed that their 20-year collaboration with Obstetrics and Gynecology (OB/GYN) would be dissolved within a year, potentially causing them to lose access to Labor and Delivery (L&D). The FM team launched a mass outreach campaign, and received over 2,000 replies in 48 hours. As a result, the decision was reversed, and a taskforce was established to further examine the issue. In February, CAFM approved a motion for four organizations from CAFM to comprise a taskforce of 8-12 people to create a playbook for pregnancy care with additional conversation around the potential for looking at other areas where residencies are under threat. In May, the CAFM taskforce joined a meeting convened by the AAFP as they had launched a new family medicine privileging initiative that rolled many of the desired outcomes of the CAFM FM Maternity Care Taskforce into it including developing a self-advocacy toolkit, related CME courses and a credentialing and privileging survey. The group met again in July. CAFM will continue to monitor the outcomes to make sure there aren't any other areas to address.

AAMC Workforce Shortage Report

In May, CAFM focused on the AAMC workforce report and its implications for primary care and since then there have been indications that the AAMC is reconsidering their initial report. CAFM/AFMAC are still interested in contributing to a letter encouraging support of primary care and also thanking AAMC for removing the message.

CAFM GOVERNMENT RELATIONS

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Congressional Activity

One Big Beautiful Bill Act

Medicaid

Congress passed and the President signed into law on July 4th the One Big Beautiful Bill Act (OBBA). The Congressional Budget Office estimates that the Senate version of the bill, which was ultimately adopted, would cut Medicaid by $930 billion over 10 years and will increase the number of uninsured Americans by 11.8 million in 2034. This is largely accomplished by stricter work requirements that will increase the administrative burden on current Medicaid recipients, limits on Medicaid expansion populations, and reductions in provider taxes. These provisions are likely to reduce Medicaid enrollment and reimbursement levels which could lead to additional hardship on rural health providers.

Rural Health Transformation Program

To address rural healthcare challenges, Section 71401 of the OBBBA establishes the Rural Health Transformation Program—a five-year, $50 billion grant initiative administered by CMS. From 2026 to 2030, states will receive $10 billion annually without needing to provide matching funds. To participate, states must submit transformation plans by December 31, 2025, detailing strategies to improve access, strengthen the workforce, enhance technology, build partnerships, and support hospital solvency. All states receive baseline funding, with additional resources allocated based on rural demographics and facility needs.

CMS has broad authority over how funds are allocated and monitored under the Rural Health Transformation Program. According to a Manatt–NRHA analysis, while the program provides time-limited support, the Medicaid cuts it attempts to offset are permanent. The funding is not limited to hospitals—it's available to a wide range of providers in all states. However, there are concerns that some recipients may not meet meaningful rural health criteria. Applications are due by December 31, 2025.

Below are further details about the program allotments:

- CMS will allocate 50% of funding equally among approved states and 50% based on rural population metrics and facility counts
- At least one-fourth of states must receive funding based on:
    - Percentage of population in rural census areas
    - Proportion of rural health facilities relative to national totals
    - Number of "deemed disproportionate share" hospitals

    - Other factors determined by the CMS Administrator
- Program activities include:
    - Promoting evidence-based, measurable interventions for prevention and chronic disease management
    - Recruiting and retaining a rural clinical workforce with a minimum five-year service commitment
    - Supporting other rural health priorities

Student Loans

The OBBA includes major reforms to student financing that will impact students. Beginning in 2026, it eliminates Graduate and Professional PLUS Loans, imposes annual and lifetime borrowing caps for professional students, and alters both Public Service Loan Forgiveness and income-driven repayment plans. The legislation also ties program eligibility to graduate earnings, potentially putting some medical education programs at risk of losing federal aid. These changes could limit access to medical education and influence the future composition of the physician workforce.

Grad PLUS Loan Program

- Eliminated – Starting July 1, 2026
- Students with Grad PLUS loans for their current program as of July 1, 2026 retain eligibility for up to 3 years.

Federal Professional Loan Borrowing Caps – Starting July 1, 2026

- Sets medical student professional loan limits at $50,000 annual, $200,000 lifetime
- House set caps at $150,000, original Senate proposal at $135,000
- Students enrolled before July 1, 2026 with existing loans are grandfathered in for up to 3 years

Institutional Accountability/ Risk Sharing – Starting July 1, 2026

- Established an accountability formula assessing the earnings of graduates 4 years after program completion, regardless of the credential level

PSLF Eligibility for Residency

- Maintained time served in a medical residency program as counting towards PSLF

Loan Interest Deferment for Medical Residents

- House bill paused student loan interest accrual during the first four

Medicare Physician Fee Schedule

The OBBA includes an increase to the Medicare Physician Fee Schedule, providing a 2.5% payment boost for calendar year 2026. This increase only applies for the calendar year 2026 and is not a long-term fix. A Kaiser Family Foundation summary of the health impacts of the OBBA can be found here.

Congressional Activities Beyond the OBBBA

THCGME Letter

The Teaching Health Center Graduate Medical Education (THCGME) Coalition continues to engage Congress on reauthorization priorities and has emphasized the need for higher annual funding than what was proposed in the near-passed December 2024 continuing resolution (CR). While congressional staff acknowledged the September 30th funding deadline, they indicated that reauthorization efforts remain in the early stages and are largely dependent on decisions from Congressional leadership. Given current dynamics and how the Senate is operating, it appears unlikely that a stand-alone Senate bill will be introduced. The THCGME Coalition recently sent a letter, signed by CAFM, urging the Senate HELP Committee to reauthorize the THCGME program that includes the requisite funding increase. Read the letter here.

House Health Subcommittee Markup on 10 Bills

On July 16, the House Energy and Commerce Health Subcommittee held a legislative hearing on rural health bills titled, "Legislative Proposals to Maintain and Improve the Public Health Workforce, Rural Health, and Over-the-Counter Medicines." The hearing memo, which includes a reference to a draft Title VII reauthorization, is available here. We submitted suggested questions to a committee member ahead of the hearing.

Administrative Activity

Stakeholders Weigh in with Concerns on USPSTF

On July 1, stakeholders sent a letter signed by 104 health organizations, including CAFM, urging Secretary Kennedy to protect the integrity of the United States Preventive Services Task Force (USPSTF), supported by the Agency for Healthcare Research and Quality (AHRQ). Since 1984, the USPSTF has employed rigorous methodologies and significant public input to formulate recommendations based on research, data, and evidence.

CMS Fee Schedule Published

On July 14, CMS released the proposed Medicare Physician Fee Schedule (PFS) for calendar year 2026. The rule aims to strengthen primary care through new quality measures, curb wasteful spending on skin substitutes, and launch a new payment model focused on chronic disease management. CAFM is reviewing the proposal and will likely join other stakeholders in submitting a comment letter during the 60-day public comment period.