# New Mexico Primary Care Training Consortium

**Southwest Center for Health Innovation; 301 W College Ave; Silver City, NM 88061**




**October 12, 2017**

Brent Earnest, Secretary
Nancy Smith-Leslie, Director, Medical Assistance Division (MAD)
New Mexico Department of Human Services
2009 S. Pacheco
Santa Fe, NM 87505

Dear Colleagues:

Thank you for the opportunity to provide public comment on the NM 1115 Waiver application: Centennial Care 2.0. The New Mexico Primary Care Training Consortium ("Consortium") appreciates your efforts to improve access to and the quality of health care for Medicaid eligible New Mexicans through Graduate Medical Education (GME) enhancements. We appreciate your understanding of the shortage of primary medical care and psychiatric care in the State and your willingness to respond through incentives for expanding residency training. Attached to this correspondence you will find:

**Attachment I**: Recommended language changes for the Centennial Care 2.0 Plan, as referenced on page 25.
**Attachment II**: Recommended regulatory language changes regarding Graduate Medical Education Payments.
**Attachment III**: Consortium letter of June 24, 2017 regarding the HSD Centennial Care 2.0 concept paper.

The Consortium recommends the following key improvements to the Medicaid GME environment:

- **Centennial Care 2.0 Draft comments (Attachment I):** The Consortium appreciates the inclusion of the GME Alternative Payment Methodology in the Plan. And while integrated primary care and behavioral health services are important to the development of the health care delivery system and Medicaid patients, we recommend clarifying the difference between funding GME for Family Medicine and Psychiatry as opposed to "Primary Care" in general, and we want to make sure that the training of family physicians, for instance, does not require an integrated Primary Care and Behavioral Health services setting. Physician training payment is specific to GME accreditation and integrated services a broader delivery concept. We would like FQHCs to receive the same or similar payment treatment as hospital-based residencies and to support rural hospital-based training development in addition to FQHC delivered residencies. We applaud the goal of adding eleven residencies in the State, however, we do not support "moving" training from hospitals to FQHCs. Instead, we propose incentivizing both accredited hospitals and FQHCs to produce the physician supply most needed by Medicaid patients and the State.

- **Regulatory Comments (Attachments II and III):**

◊ Overall, we recommend that all GME-related regulations be separate from the Hospital PPS Regulations section. Non-PPS/DRG hospitals and community-based organizations should be also eligible for at least Direct GME payments. It seems more expedient to have a specific GME section with references to provider categories than having GME payment regulations "peppered" throughout state regulations.

◊ GME – Indirect Graduate Medical Education (IME) payments. We recommend eliminating the 125 resident-threshold for PPS hospitals so that hospitals other than UNM may receive IME support. The threshold was established at a time when there was only one large program in the State (e.g., UNM). Today there are several hospitals engaged in residencies that are operating at a relative financial disadvantage when in fact, their training programs are well designed in terms of meeting the State's need for primary care professionals. These programs should not bear a disproportionate cost burden for meeting state needs. Current New Mexico Medicaid IME payments support an 8:2 ratio of subspecialty to primary care resident training. Most subspecialty residents do not practice in New Mexico subsequent to graduation, as opposed to family physicians.

◊ GME – Direct Graduate Medical Education (DGME) payments.

⇒ We recommend a structure of DGME payments that provides significant incentives for family medicine, psychiatric and rural based training. We suggest that other specialties may be added to the primary care (PC) and rural definitions however, such as pediatric and internal medicine, but there should be an evaluation of their effectiveness in meeting the needs of the State for primary care services over time.

⇒ We support a combined $75,000 PC and Rural DGME payment level and a $50,000 "other" payment level, both adjusted for inflation during the current regulatory period.

⇒ We support an Administrative Cost add-on to the base DGME rate for hospitals and FQHCs not otherwise eligible for IME. The 2015 national Medicare IME: DGME ratio was 1.9:1. Currently, in New Mexico there is an IME: DGME ratio of 5.1:1. We recommend a 1:1 ratio (DGME to Administrative Cost ratio) for FQHCs and hospitals that are not eligible for IME as part of the DGME payment methodology.

◊ The current State Plan Amendment has put FQHCs at a disadvantage as the approved Medicaid eligibility limitations for FQHCs are less equitable than the hospital requirements in the regulations. In addition, FQHC DGME payments fluctuate based on percentage of Medicaid visits annually as opposed to fixed payments by specialty in the hospital setting. FQHCs must also currently identify matching funds as opposed to hospitals that can simply add residencies costs and be paid from the Medical payments budget within MAD (see Lovelace Hospital DGME payment history). Therefore, we seek to add FQHCs to the regulatory environment that allows FQHCs the same treatment as hospitals training the same type of residents in nationally accredited residency programs with the same quality standards. And while hospital IME payments adjust based on number of hospital beds and residents, the fixed or direct costs or training do not differ by environment. We also suggest that accreditation, not Medicaid volume, be the determining factor in FQHC eligibility. Hospitals are required only to have a 5% Medicaid patient mix to be eligible for payments. FQHCS are limited to the six FQHCs with the highest percentage of Medicaid patients. This is also inequitable. All rural and community-based training programs have higher primary care residency training numbers overall and are more successful in graduating physicians who more likely to work in rural and underserved areas. Medicaid regulations should encourage an increased supply of primary care providers by providing incentives for training in accredited programs.

In summary, the Consortium would like to solidify the role and support of various primary care and rural health providers in their efforts to enhance the training of the future New Mexico physician workforce through Medicaid GME and Medicare financing whenever possible. The current regulatory environment and State Plan Amendment do not adequately create the environment necessary to support physician workforce development relative to the needs of the State. Today, our state needs between 200 to 400 primary care and psychiatric physicians while we continue to train the same number of family physicians as in 1997. New Mexico has the oldest physician workforce and the problem will only be exacerbated over the next decade. The shortages are a national issue, and New Mexico cannot solely rely on other states to resolve these shortage issues. Moreover, the nation is seeing a reduction in the availability of obstetrical services, especially in rural areas. From a New Mexico-specific Medicaid perspective, traveling long distances to obtain delivery services is: 1) problematic for Medicaid eligible individuals; 2) expensive to the program; 3) raises concerns about patient safety and health outcomes; and 4) the absence of locally available health services is a significant economic development issue. The resolution to this problem and other issues of access to comprehensive care resides in training full spectrum family medicine providers that deliver babies, general surgery and other primary care specialties and psychiatry.

Again, thank you for the opportunity for this input and we would like to have a follow-up meeting with our key partners including the University of New Mexico, Burrell College of Osteopathic Medicine, Memorial Medical Center and Consortium staff to further discuss the proposed regulatory changes.

Sincerely,

Charlie Alfero
Charlie Alfero (Oct 13, 2017)

Charles Alfero, Executive Director

John Andazola, MD
John Andazola, MD (Oct 11, 2017)

John Andazola, MD, President

**Cc:**
New Mexico Hospital Association
New Mexico Primary Care Association
New Mexico Primary Care Training Consortium Board of Directors
Interested Parties

**Enclosures:**
Attachment I: Recommended language changes for the Centennial Care 2.0 Plan, as referenced on page 25.
Attachment II: Recommended regulatory language changes regarding Graduate Medical Education Payments.
Attachment III: Consortium letter of June 24, 2017 regarding the HSD Centennial Care 2.0 concept paper.

**ATTACHMENT I:** Recommended language changes for the Centennial Care 2.0 Plan;
(Language of page 25 of the Centennial Care Plan 2.0 draft)

Below are the recommended changes to the Plan.

**Original language:**

**"Physical and Behavioral Health Integration Proposal #2: Establish an alternative payment methodology to support workforce development**

HSD Proposes an alternative payment methodology for graduate medical education to enhance current payment rates, with the goal of increasing and improving access to care in rural and frontier regions of New Mexico by moving primary care and psychiatric residents from hospitals to community-based clinic settings. Under the proposed methodology, HSD will fund up to ten residencies statewide in community-based provider settings with high numbers of attributed Medicaid patients. The community-based clinic will be required to meet HSD-establish criteria to be eligible for the alternative payment. The criteria may include the type of residency program offered, numbers and types of Medicaid clients served, and other categories of residency programs."

**Recommended changes with tracked edits**:

"~~**Physical and Behavioral Health Integration Proposal #2:**~~ **Establish a**~~**n alternative**~~ **payment methodology to support primary care and behavioral health / psychiatric residency** ~~**workforce**~~ **development and integration including FQHCs#2: Expand Direct and Indirect Medical Education payments to create incentives for primary care, psychiatric and rural hospital graduate medical education programs.**

HSD Proposes improvements in payment regulations ~~an alternative payment methodology~~ for graduate medical education to enhance current payment rates, with the goal of increasing and improving access to care in rural and frontier regions of New Mexico by ~~moving~~incentives for creating community-based and rural hospital-based primary care and psychiatric resident~~ts~~cy programs ~~from~~ in rural hospitals ~~to~~and community-based clinic settings. Under the proposed ~~methodology~~regulatory changes, HSD will fund up to ten expanded or newly accredited residencies statewide in community-based provider settings~~.s with high numbers of attributed Medicaid patients~~. ~~The community-based clinic~~Residencies will be required to meet HSD-establish criteria to be eligible for the ~~alternative~~ indirect and direct graduate medical education payment. The criteria may include the type of residency program offered, numbers and types of Medicaid clients served, and other categories of residency programs."

**Recommended changes; clean version:**

**"Establish a payment methodology to support primary care and behavioral health / psychiatric residency development and integration #2: Expand Direct and Indirect Medical Education payments to create incentives for primary care, psychiatric and rural hospital graduate medical education programs in rural hospital and community-based settings.**

HSD Proposes improvements in payment regulations for graduate medical education to enhance current payment rates, with the goal of increasing and improving access to care for Medicaid patients in rural and frontier regions of New Mexico by creating incentives for community and rural hospital-based primary care and psychiatric residency programs. Under the proposed regulatory changes, HSD will fund up to ten new and/or expanded accredited residencies statewide. Residencies will be required to meet HSD-establish criteria to be eligible for the indirect and direct graduate medical education payments. The criteria may include the type of residency program offered, numbers and types of Medicaid clients served, and other categories of residency programs."

**ATTACHMENT II:** Recommended regulatory language changes regarding Graduate Medical Education Payments.

**Summary of Changes:**

- IME - Make all PPS/DRG hospitals with approved residencies eligible for IME, not just those with more than 125 residents. We are not sure if the State can add Medicaid IME to hospitals that get paid a different Medicare scheme such as a "Hospital Specific Rate", but they are not eligible for Medicare IME except for their Medicaid Plus business which is minimal.
- Direct GME - Combine Rural and Primary Care residencies into one rate. The current difference is negligible and the incentives should be significant in favor of PC and Rural
- Set Payment rate at $75,000 for PC and Rural and $50,000 for "Other" which are the subspecialties. Currently, UNM has a sub-specialists / primary care training ratio of 8:2. This is typical in Academic Medical Centers and teaching hospitals nationally and a large part of the reason there is a severe shortage of primary care providers in the state and nation. The recommended ratio of training is 1:1. To get there, significant incentive must be provided to training institutions for primary care and psychiatric development.
- In 2017, HSD removed a cap on DGME subspecialty training payments. We are recommending that HSD reset the ratio of DGME to 40.4% for other "other" and 59.6% for rural and primary care training to limit Medicaid growth in Subspecialties for future distribution of GME support.
- Add FQHCs to the DGME definition.
- The 2015 national Medicare IME to DGME ratio is 1.9:1 (2015). The UNM rate for Medicaid is 5.1:1, IME: DGME. In our recommendation, we suggest that hospitals and FQHCs that are not eligible for IME by definition, receive and administrative cost add-on of 1:1 on the $75,000 DGME fixed rate for rural and primary care residencies.
- The current State Plan Amendment separates FQHCs from the GME regulations this approach is limiting:

    - HSD is requiring identification of funding for FQHC-based training but not hospitals. This is a disincentive for residency development financially and creates a less secure financing environment for FHQC. This is an inequitable policy and should be changed to removed barriers to primary care development.
    - HSD is requiring a higher standard of Medicaid patient eligibility for FQHCs than hospitals – top 6 FQHCs vs any hospital with over 5% Medicaid patients. There is no relationship between Medicaid patient mix and residency accreditation. ACGME residency accreditation should be the standard for Medicaid GME payment eligibility. The proposed Centennial Care Plan already limits the maximum development to 11 residencies.
    - Hospitals have a fixed rate of DGME payments – FQHCs vary annually based on Medicaid patient visits. Residency development is a large investment for providers requiring predictability such as the Medicare and Medicaid hospital payment environment.
    - Eligible Definitions to include: family medicine, psychiatry, Ob/GYN, general surgery, general pediatrics and general internal medicine (suggest an evaluation of practice and specialty and five years completion of the residency program with a standard of at least 60% of residency program grads from rural and primary care training programs still practicing in the defined provider specialties above.
    - Secretary of HSD has agreed to consider efforts to level the playing field through regulation. See recommendations below.

Suggested language improvements for Medicaid GME:

**TITLE 8 SOCIAL SERVICES**
**CHAPTER 311 HOSPITAL SERVICES**
**PART 3 METHODS AND STANDARDS FOR ESTABLISHING PAYMENT-INPATIENT HOSPITAL SERVICES**

**8.311.3.12 PROSPECTIVE PAYMENT METHODOLOGY FOR HOSPITALS**
**(This section should be separated section from Part 3 since DGME payments can go to Non-PPS hospitals and FQHCs)**

**(6) Indirect medical education (IME) adjustment:** Effective XXXX, each acute care hospital that qualifies as a teaching hospital will receive an IME payment adjustment, which covers the increased operating or patient care costs that are associated with approved intern and resident programs. The IME payment adjustment is subject to available state and federal funding, as determined by the department and shall not exceed any amounts specified in the *medicaid state plan*.

**(a)** In order to qualify as a teaching hospital and be deemed eligible for an IME adjustment, the hospital must:

**(i)** be licensed by the state of New Mexico; and

**(ii)** be reimbursed on a DRG basis under the plan; and

**(iii)** operate an accredited residency program, as defined by medicare in 42 CFR 413.75, either directly, or through a contractual relationship with a separate sponsoring institution. This would include independently accredited, multiple programs under a single ACGME sponsoring institution or Rural Training Track (RTT) programs. No two facilities may claim IME costs for the same resident FTE.

**(b)** Determination of a hospital's eligibility for an IME adjustment will be done annually by the department, as of the first day of the provider's fiscal year. If a hospital meets the qualification for an IME adjustment after the start of its fiscal year, it will be deemed eligible for the IME adjustment beginning on the first day of the quarter after the date the qualification were met.

**(c)** The IME payment amount is determined by multiplying DRG operating payments, which are DRG payments and outlier payments, by the IME adjustment factor computed by the following formula:

$1.89*((1+R)^{.405}-1)$

where R equals the number of approved full-time equivalent (FTE) residents divided by the number of available beds (excluding nursery and neonatal bassinets). FTE residents are counted in accordance with 42 CFR 412.105(f), except that the limits on the total number of FTE residents in 42 CFR 412.10(f)(1)(iv) shall not apply, and at no time shall exceed 450 FTE residents in any institution. For purposes of this paragraph, DRG operating payments include the estimated average per discharge amount that would otherwise have been paid for MAD managed care enrollees if those persons had not been enrolled in managed care.

**(d)** Quarterly IME payments will be made to qualifying hospitals at the end of each quarter. Prior to the end of each quarter, the provider will submit to the department's audit agent the information necessary to make the calculation, i.e. number of beds, number of estimated residents for the quarter, and the MAD DRG amount. After review and adjustment, if necessary, the audit agent will notify the department of the amount due to/from the provider for the application quarter. Final settlement of the IME adjustment amount will be made through the cost report; that is, the number of beds, residents, and DRG

amounts used in the quarterly calculation will be adjusted to the actual numbers shown on the provider's cost report for those quarters.

**(7) Payment for direct graduate medical education – Suggest this be moved to a separate section with or with section 6 above since it is in the PPS section and all hospitals are eligible for DGME regardless of DRG status (DGME):** Subject to federal government approval of a corresponding amendment to the *medicaid state plan*, effective for services provided on or after July 1, 1998, payment to hospitals and Federally Qualified Health Centers (FQHCs) for DGME expense is made on a prospective basis as described in this section. Payments will be made quarterly to qualifying hospitals and FQHCs, at a rate determined by the number of resident full-time-equivalents (FTEs) in the various categories defined below, who worked at the hospital or FQHC during the preceding year. (relates only to DRG hospitals). The DGME payment is subject to available state and federal funding, as determined by the department, and shall not exceed any amounts specified in the *medicaid state plan*.

**(a)** To be counted for MAD reimbursement, a resident must be participating in an approved medical residency program, as defined by medicare in 42 CFR 413.75. With regard to categorizing residents, as described in Subparagraph (b) of Paragraph (9) below, the manner of counting and weighting resident FTEs will be the same as is used by medicare in 42 CFR 413.79 except that the number of FTE residents shall not be subject to the FTE resident cap described in 42 CFR 413.79(b)(2). Resident FTEs whose costs will be reimbursed by the department as a medical expense to a federally qualified health center are eligible for reimbursement under this section. To qualify for MAD DGME payments, a hospital or FQHC must be licensed by the state of New Mexico, be currently enrolled as a MAD provider, and must have achieved a MAD patient utilization rate of five percent or greater during its most recently concluded hospital or FQHC fiscal year. For the purposes of this section, the MAD patient utilization rate will be calculated as the ratio of New Mexico MAD eligible days, including patient days paid under MAD managed care arrangements, to total inpatient hospital days for eligible hospitals and the ratio of Medicaid patients to total patients in the case of an FHQC.

**(b)** Approved resident FTEs are categorized as follows for MAD GME payment:

**(i) Primary care/obstetrics resident.** Primary care is defined per 42 CFR 413.75(b) and **rural health resident.** A rural resident is defined as participating in a designated rural health residency program. Residents enrolled in a designated rural health residency program will be counted as a rural health resident FTE for the entire duration of their residency, including those portions of their residency which may be served in a non-rural hospital or clinic.

**(ii) Other approved resident.** Any resident not meeting the criteria in Item (i), above.

**(c) MAD GME payment amount per resident FTE:**

**(i)** The annual MAD payment amount per resident FTE with state fiscal year 2017 is as follows:

Primary care/obstetrics and Rural Health resident: $75,000

Other resident: $50,000

**(ii)** The per resident amounts specified in Item (i) of Subparagraph (c) of Paragraph (9) of Subsection F of 8.311.3.11 NMAC will be inflated for state fiscal years beginning on or after July 1, 2017 using the annual inflation update factor described in Item (ii) of Subparagraph (d) of Paragraph (7) of Subsection F of 8.311.3.11 NMAC.

**(d) Annual inflation update factor:**

**(i)** Effective for state fiscal years 2000 and beyond, the department has updated the per resident GME amounts and the upper limit on GME payments for inflation, using the market basket forecast published in the CMS Dallas regional medical services letter issued for the quarter ending in March 1999 to determine the GME rates for state fiscal year 2000 (July 1, 1999 - June 30, 2000).

**(ii)** The department will use the market basket forecast shown for hospitals and FQHCs that is applicable to the period during which the rates will be in effect. MAD will determine the percentage of funds available for GME payments to eligible hospitals and FQHCs.

**(e) Annual upper limits on GME payments:**

**(i)** Total annual MAD GME payments will be limited to $18,500,000 for state fiscal year 2017. This amount will be updated for inflation, beginning with state fiscal year 2018 or in specified amounts included in the state budget, in accordance with Subparagraph (d) of Paragraph (7) of Subsection F of 8.311.3.11 NMAC.

**(ii)** Total annual GME payments for residents in Category B.3, "Other," will be limited to the following percentage of the $18,500,000 total annual limit (as updated for inflation or as specified in the state budget in accordance with Subparagraph (d) of Paragraph (7) of Subsection F of 8.311.3.11 NMAC):

state fiscal year 2018 and thereafter 40 percent

(f) For hospitals ineligible for IME pursuant to Section F.6. above, in recognition of Administrative and related facilities costs for non-DRG hospitals, such as Sole Community Hospitals receiving a hospital specific rate and FQHC residencies shall be paid an administrative fee amount equal to the amount of payment in section F. (7) C. (i) above for primary care and rural residents.

**(g) Reporting and payment schedule:**

**(i)** Hospitals and FQHCs will count the number of residents working according to the specification in this part during each fiscal year (July 1 through June 30) and will report this information to the department by December 31. Counts will represent the weighted average number of residents who worked in the hospitals or FHQC during the specified 12-month period. Hospitals and FQHCs may also add to this count any FTEs associated with newly approved residency programs that will be implemented on or before the start of the prospective DGME payment year, to the extent that these FTEs are not already reflected in the weighted average counts of the preceding year. To illustrate, resident FTE amounts would be counted from 07/01/96 - 06/30/97 for the payment year 07/01/98 - 06/30/99. The department may require hospitals and FQHCs to provide documentation necessary to support the summary counts provided.

**(ii)** The department will establish the amount payable to each hospital and FQHC for the prospective payment period that will begin each July 1. Should total payments as initially calculated exceed either of the limitations in Subsection D of 8.311.3.11 NMAC, the amount payable to each will be proportionately reduced.

**(iii)** The annual amount payable to each hospital and FQHC is divided into four equal payments. These payments will be made by the department on or about the start of each prospective payment quarter.

**(iv)** Should a facility not report timely with the accurate resident information as required in Item (i) of Subparagraph (f) of Paragraph (7) of Subsection F of 8.311.3.11 NMAC above, it will still be entitled to receive payment for any quarter yet remaining in the prospective payment year, after acceptable information has been submitted. However, payments to untimely reporting facilities will be limited to the amount of funds that remain available under the upper limits described in Subsection D of 8.311.3.11 NMAC, after prospective payment amounts to timely filing facilities have been established.

[8.311.3.12 NMAC - Rp, 8.311.3.12 NMAC, 6/1/2016]

**Attachment III**: Consortium letter of June 24, 2017 regarding the HSD Centennial Care 2.0 concept paper

# New Mexico Primary Care Training Consortium

**Southwest Center for Health Innovation; 301 W College Ave; Silver City, NM 88061**




**June 24, 2017**

**Brent Earnest, Secretary**
**Nancy Smith-Leslie, Director, MAD**
**New Mexico Department of Human Services**
**2009 S. Pacheco**
**Santa Fe, NM 87505**

Dear Colleagues:

Thank you for the opportunity to comment on the 2017 HSD, MAD Section 1115 Demonstration Waiver Renewal Concept Paper. We appreciate your support of the need of the state to develop community and hospital-based training programs for primary care. We especially appreciate specific mentions of the FQHC strategy and would like to offer some points of clarification for future administrations to ensure continuity and financing stability for programs that may develop, now that you have obtained an approved CMS State Plan Amendment (SPA) for those purposes.

Our primary concerns center around eligibility issues: program and cost inclusion. Since Medicaid will only pay its share of residency costs based on the percentage of Medicaid visits in Accreditation Council of Graduate Medical Education (ACGME) accredited programs, we believe it is unnecessary to limit financing to the top six FQHCs relative to percentage of Medicaid patients. The percentage of Medicaid patients in any given FQHC is technically unrelated to the sites' ability to train physicians. For example, if a location has a single physician assistant or nurse practitioner with eighty percent Medicaid patients, they may fall into the top six FQHCs, but may not be a likely residency site. We recommend the following:

- ACGME accreditation be the standard for FQHC eligibility, and that sites be added based on availability of funds for those purposes.
- Clarify language on the current SPA concerning Graduate Medical Education (GME) Direct Medical Education (DME) allowable expenses, as such in the Medicare DME definitions. For your reference, we have provided a laundry list of typical DME allowable expenses in Attachment I.
- Provide Indirect Graduate Medical Education (IME) support for the hospital's portion of the training costs so that more hospitals may be inclined to support FQHC resident required hospital experiences (see Attachment 1). Since the State will only pay the Medicaid visit percentage of the program, there is no likelihood of the program being eligible for Medicare payment duplication. Certainly, no other organization should claim DME expenses for FQHC resident-related costs.

Moreover, Hospital-related GME payment statutes / regulations may inhibit the development of primary care and rural residencies statewide: **Section 8.311.3.12 - PROSPECTIVE PAYMENT METHODOLOGY FOR HOSPITALS.** This may or may not be part of the proposed Centennial Care 2.0 plan revisions discussion; however, it is related to the State's ability to train primary care providers, including psychiatry. Current regulations limit IME payments to hospitals with 125 or more residents, more specifically, the University of New Mexico (see Attachment 2, Section F.6.a.iii). If we agree that it is a benefit to Medicaid patients in terms of access to appropriate levels of care, we suggest that, since Medicaid will only make payments limited to a hospital's Medicaid share, that hospitals with fewer residents based on ACGME allowed numbers, be permissible. Also, if possible, a hospital should be able to receive Medicaid IME payments regardless of its Medicare payment category limitations.

**Southwest Center for Health Innovation; 301 W College Ave; Silver City, NM 88061**

Direct GME payment thresholds should provide incentives for primary care and rural residents as opposed to "other" residents. The current payment structure rewards training of physicians in expensive sub-specialties for which there is much less demand when compared to primary care providers (as defined in Attachment I). However, in this case, rural OB/GYN, Hospitalists, and General Surgery residents could be added to increase the potential for rural hospital sustainability. We suggest a $75,000 Primary Care and Rural Direct GME payment and a $50,000 "other" or a similar model. The payment rate should be based on incentivizing a more cost-effective, primary care-oriented health system and not incentivizing high-cost sub-specialties with higher GME payments simply because they are more expensive. That perspective is inflationary and unrelated to a rational or desirable Medicaid-financed health care system. In other words, focus on value rather than cost to meet outcome and growth goals.

In 2017, the state provision requiring that 59.6% of all Medicaid hospital GME expenses be used for primary care and rural residents expired. This allows 100% of Medicaid resources to be spent on "other" - specialists or subspecialists for which there may not be a relative demand in the state. Most subspecialists trained in the State also leave the State (see Attachment 2 highlights; Section F.6.e.ii). This does not support an affordable Medicaid program and does not focus limited state funds on the primary care or rural hospital system. In fact, we believe the majority of Medicaid funds be directed to primary care training of general specialists, such as those listed in Attachment I, especially where the program can prove that the graduating general specialists practice in primary care for a given period of time after residency completion and prior to subspecialty fellowship. Current data show that 90% or more of General Internists never practice in primary care. The same is true for over 60% of Pediatricians. National recommendations are for a 50-50 split in primary care and subspecialty mix and we believe the GME payment system should reflect growing the workforce from this perspective, which requires a significant enough investment to adjust the currently, sub-specialty heavy GME system. However, due to the rural nature of our State, public funds should be disproportionately used to support affordable, preventive and primary care focused health care.

In addition, there are currently other state general funds used to support residency rotations and program operations that are not part of the Medicaid payment system. We would request discussions with MAD and other impacted organizations to determine if there is an opportunity to increase residency support through Medicaid without additional state general fund commitments.

Lastly, we would ask the MAD to consider reinstating the contract to NMPCTC for residency development and maintenance and suggest that state general funds appropriated for those purposes be matched administratively through CMS to optimize financial support of the program. It is incredibly clear, after several years of development work, that communities require technical support of residency development, both in terms of accreditation applications and maximizing payments from federal and state sources, in terms of ongoing residency support.

Thanks again for the opportunity to provide input into the Centennial Care 2.0 development process. We look forward to working with you on these and other very important issues moving forward.

Sincerely,

Charlie Alfero
Charlie Alfero (Jun 26, 2017)

**Charlie Alfero, Director**

John Andazola, MD
John Andazola, MD (Jun 26, 2017)

**John Andazola, MD, Board President**

**Enclosures:**

Attachment I—Suggested changes in the Alternative Payment Methodology for the Centennial Plan 2.0

Attachment II—Prospective Payment Methodology for Hospitals

**Attachment 1**

Centennial Care 2.0 Draft: (page 17)

**Physical and Behavioral Health Integration Opportunity #2: Establish an alternative payment methodology to support workforce development.**

To support workforce development and improve access to care, New Mexico proposes to establish an alternative payment methodology to support training for both primary care and psychiatric resident physicians deployed in community-based practices in very rural and underserved parts of New Mexico. The alternative payment will be designed to fully support resident physicians is areas of the state where it is particularly difficult to attract health care providers. Such payments are both economic and efficient because they will facilitate access to care Medicaid recipients in the least expensive settings in their communities.

Current State Plan Amendment Language for alternative payment methodology:

Beginning January 1, 2016, FQHCs that train primary care resident physicians at the FQHC are eligible for an alternate payment methodology that will enhance the PPS rate.

A primary care resident physician is an individual with a New Mexico post graduate training license who is enrolled in a New Mexico primary care residency program.

The alternate payments are limited to six FQHCs. The Department will post this information on its website on an annual basis.

i. In order to be eligible for the alternate payment, the FQHC must complete an agreement with the state agency under which the FQHC will report, on a quarterly basis, the hours worked by primary care resident physicians and the percentage of patients treated at the FQHC who are Medicaid eligible at the time of service. The agreement will include a statement that both the FQHC and the Department agree to all provisions for the alternate payment and require an attestation from the FQHC that enhanced funding paid under this provision will not supplant or duplicate residency funding paid by the Medicare program. Prior to the Department's approval of the agreement, the FQHC must provide their agreement with the hospital.

For each FQHC:

Medicaid FTE = Total FTEs x ratio of Medicaid patients to all patients

ii. The alternate payment is made through a settlement process based on the number of hours worked by primary care resident physicians, which is multiplied by the resident physician's hourly rate, and which is multiplied by the ratio of the Medicaid encounters to all encounters for the time period.

iii. The payment to an FQHC for primary care resident physicians will not

exceed an FQHC's Medicaid share for training primary care resident physicians, as calculated in subparagraph (i), above; divided by the total of all participating FQHCs' Medicaid share for training primary care resident physicians, which results in a percentage.
iv. Alternate payments made in accordance with this methodology will be distributed on a quarterly basis.

Suggested changes in the Alternative Payment Methodology for the Centennial Plan update:

Beginning January 1, 2016, FQHCs that train primary care resident physicians at the FQHC are eligible for an alternate payment methodology that will enhance the current PPS rate.

A primary care resident physician is an individual with a New Mexico post graduate training license who is enrolled in an ACGME accredited New Mexico primary care residency program or participates under contract with an American Council on Graduate Medical Education (ACGME) accredited residency program to train primary care residents, including Family Medicine, General Pediatrics, General Internal Medicine; and, General, Pediatric or Rural Psychiatry.

The alternate payments are limited to FQHCs that have achieved accreditation from the ACGME, either independently or as an affiliated partner of an existing ACGME-accredited program. Approvals of applications for residency payment will be based on the number of ACGME approved positions and the availability of funds through appropriation or through local matching funds provided through intergovernmental transfer from eligible public sources.

i. To be eligible for the alternate payment, the FQHC must complete an agreement with the state agency under which the FQHC will report, on a quarterly basis, the number of full-time equivalent residents in training, and the percentage and number of Medicaid eligible patient visits at the FQHC. The agreement will include a statement that both the FQHC and the Department agree to all provisions for the alternate payment and require an attestation from the FQHC that enhanced funding paid under this provision will not supplant or duplicate residency funding paid by the Medicare program. Prior to the Department's approval of the agreement, the FQHC must provide their agreements with the ACGME-accredited Sponsoring Institution and the affiliated hospital(s) involved in training.

For each FQHC:

Medicaid FTE = Total FTEs x ratio of Medicaid patient visits to all patient visits

ii. The alternate payment is made through a settlement process based on the number of full-time time equivalent primary care residents during the reporting period and associated total Direct Graduate Medical Education (DGME) costs to include: resident salaries, fringe benefits, supplies, faculty-related costs, ACGME-required costs such as Designated Institutional Official, and related administrative costs, and training-related direct costs such as licensure and certification fees, conference expenses, one-time moving expenses, work-related travel and housing for rotation experiences consistent with the ACGME-approved curriculum, resident and faculty recruiting expenses and other related direct costs justified by the FQHC. Hospital training costs may be allowed if the hospital is ineligible for Medicare Indirect Medical Education (IME) payments and the hospital does not receive GME payments for FQHC residents from Medicaid.

iii. The payment to an FQHC for primary care resident physician costs described in part ii above will not exceed an FQHC's Medicaid share for training primary care resident physicians, as calculated in subparagraph (i), above, which results in a percentage of Medicaid eligible expenses or the Medicaid share of costs.

iv. Alternate payments made in accordance with this methodology will be distributed on a quarterly basis.

# Attachment II

**TITLE 8 SOCIAL SERVICES**
**CHAPTER 311 HOSPITAL SERVICES**
**PART 3 METHODS AND STANDARDS FOR ESTABLISHING PAYMENT-INPATIENT HOSPITAL SERVICES**

**8.311.3.12 PROSPECTIVE PAYMENT METHODOLOGY FOR HOSPITALS**

**F. (6) Indirect medical education (IME) adjustment:** Effective August 1, 1992, each acute care hospital that qualifies as a teaching hospital will receive an IME payment adjustment, which covers the increased operating or patient care costs that are associated with approved intern and resident programs. The IME payment adjustment is subject to available state and federal funding, as determined by the department and shall not exceed any amounts specified in the *medicaid state plan*.

**(a)** In order to qualify as a teaching hospital and be deemed eligible for an IME adjustment, the hospital must:

**(i)** be licensed by the state of New Mexico; and

**(ii)** be reimbursed on a DRG basis under the plan; and

**(iii)** operate an ACGME accredited residency program either directly or through a contractual relationship with separate sponsoring institution. enrolled in approved teaching programs.

**(b)** Determination of a hospital's eligibility for an IME adjustment will be done annually by the department, as of the first day of the provider's fiscal year. If a hospital meets the qualification for an IME adjustment after the start of its fiscal year, it will be deemed eligible for the IME adjustment beginning on the first day of the quarter after the date the qualification were met.

**(c)** The IME payment amount is determined by multiplying DRG operating payments, which are DRG payments and outlier payments, by the IME adjustment factor computed by the following formula:

$$1.89*((1+R)^{.405}-1)$$

where R equals the number of approved full-time equivalent (FTE) residents divided by the number of available beds (excluding nursery and neonatal bassinets). FTE residents are counted in accordance with 42 CFR 412.105(f), except that the limits on the total number of FTE residents in 42 CFR 412.10(f)(1)(iv) shall not apply, and at no time shall exceed 450 FTE residents. For purposes of this paragraph, DRG operating payments include the estimated average per discharge amount that would otherwise have been paid for MAD managed care enrollees if those persons had not been enrolled in managed care.

**(d)** Quarterly IME payments will be made to qualifying hospitals at the end of each quarter. Prior to the end of each quarter, the provider will submit to the department's audit agent the information necessary to make the calculation, i.e. number of beds, number of estimated residents for the quarter, and the MAD DRG amount. After review and adjustment, if necessary, the audit agent will notify the department of the amount due to/from the provider for the application quarter. Final settlement of the IME adjustment amount will be made through the cost report; that is, the number of beds, residents, and DRG amounts used in the quarterly calculation will be adjusted to the actual numbers shown on the provider's cost report for those quarters.

**(7) Payment for direct graduate medical education (GME):** Subject to federal government approval of a corresponding amendment to the *medicaid state plan*, effective for services provided on or after July 1, 1998, payment to hospitals for GME expense is made on a prospective basis as described in this section. Payments will be made quarterly to qualifying hospitals, at a rate determined by the number of resident full-time-equivalents (FTEs) in the various categories defined below, who worked at the hospital during the preceding year, and subject to an upper limit on total payments. The GME payment is subject to available state and federal funding, as determined by the department, and shall not exceed any amounts specified in the *medicaid state plan*.

**(a)** To be counted for MAD reimbursement, a resident must be participating in an approved medical residency program, as defined by medicare in 42 CFR 413.75. With regard to categorizing residents, as described in Subparagraph (b) of Paragraph (9) below, the manner of counting and weighting resident FTEs will be the same as is used by medicare in 42 CFR 413.79 except that the number of FTE residents shall not be subject to the FTE resident cap described in 42 CFR 413.79(b)(2). Resident FTEs whose costs will be reimbursed

by the department as a medical expense to a federally qualified health center are not eligible for reimbursement under this section. To qualify for MAD GME payments, a hospital must be licensed by the state of New Mexico, be currently enrolled as a MAD provider, and must have achieved a MAD inpatient utilization rate of five percent or greater during its most recently concluded hospital fiscal year. For the purposes of this section, the MAD inpatient utilization rate will be calculated as the ratio of New Mexico MAD eligible days, including inpatient days paid under MAD managed care arrangements, to total inpatient hospital days.

**(b)** Approved resident FTEs are categorized as follows for MAD GME payment:

**(i)** **Primary care/obstetrics resident.** Primary care is defined per 42 CFR 413.75(b).

**(ii)** **Rural health resident.** A resident is defined as participating in a designated rural health residency program. Residents enrolled in a designated rural health residency program will be counted as a rural health resident FTE for the entire duration of their residency, including those portions of their residency which may be served in a non-rural hospital or clinic. Should any resident meet the criteria for both rural health and primary care in this section, this resident will be counted as a rural health resident.

**(iii)** **Other approved resident.** Any resident not meeting the criteria in Items (i) or (ii), above.

**(c)** **MAD GME payment amount per resident FTE:**

**(i)** The annual MAD payment amount per resident FTE with state fiscal year 2017 is as follows:

| | |
|---|---|
| Primary care/obstetrics resident: | $41,000 |
| Rural health resident: | $52,000 |
| Other resident: | $50,000 |

**(ii)** The per resident amounts specified in Item (i) of Subparagraph (c) of Paragraph (9) of Subsection F of 8.311.3.11 NMAC will be inflated for state fiscal years beginning on or after July 1, 2017 using the annual inflation update factor described in Item (ii) of Subparagraph (d) of Paragraph (7) of Subsection F of 8.311.3.11 NMAC.

**(d)** **Annual inflation update factor:**

**(i)** Effective for state fiscal years 2000 and beyond, the department has updated the per resident GME amounts and the upper limit on GME payments for inflation, using the market basket forecast published in the CMS Dallas regional medical services letter issued for the quarter ending in March 1999 to determine the GME rates for state fiscal year 2000 (July 1, 1999 - June 30, 2000).

**(ii)** The department will use the market basket forecast shown for PPS hospitals that is applicable to the period during which the rates will be in effect. MAD will determine the percentage of funds available for GME payments to eligible hospitals.

**(e)** **Annual upper limits on GME payments:**

**(i)** Total annual MAD GME payments will be limited to $18,500,000 for state fiscal year 2017. This amount will be updated for inflation, beginning with state fiscal year 2018, in accordance with Subparagraph (d) of Paragraph (7) of Subsection F of 8.311.3.11 NMAC.

**(ii)** Total annual GME payments for residents in Category B.3, "Other," will be limited to the following percentages of the $18,500,000 total annual limit (as updated for inflation in accordance with Subparagraph (d) of Paragraph (7) of Subsection F of 8.311.3.11 NMAC):

| | |
|---|---|
| state fiscal year 1999 | 58.3 percent |
| state fiscal year 2000 | 56.8 percent |
| state fiscal year 2001 | 53.3 percent |
| state fiscal year 2002 | 50.7 percent |
| state fiscal year 2003 | 48.0 percent |
| state fiscal year 2004 | 45.5 percent |
| state fiscal year 2005 | 43.0 percent |
| state fiscal year 2006 | 40.4 percent |
| state fiscal year 2017 and thereafter | no limit |

**(f)** **Reporting and payment schedule:**

**(i)** Hospitals will count the number of residents working according to the specification in this part during each fiscal year (July 1 through June 30) and will report this information to the department by December 31. Counts will represent the weighted average number of residents who worked in the hospitals during the specified 12-month period. Hospitals may also add to this count any FTEs associated with

newly approved residency programs that will be implemented on or before the start of the prospective GME payment year, to the extent that these FTEs are not already reflected in the weighted average counts of the preceding year. To illustrate, resident FTE amounts would be counted from 07/01/96 - 06/30/97 for the payment year 07/01/98 - 06/30/99. The department may require hospitals to provide documentation necessary to support the summary counts provided.

**(ii)** The department will establish the amount payable to each hospital for the prospective payment period that will begin each July 1. Should total payments as initially calculated exceed either of the limitations in Subsection D of 8.311.3.11 NMAC, the amount payable to each will be proportionately reduced.

**(iii)** The annual amount payable to each hospital is divided into four equal payments. These payments will be made by the department on or about the start of each prospective payment quarter.

**(iv)** Should a facility not report timely with the accurate resident information as required in Item (i) of Subparagraph (f) of Paragraph (7) of Subsection F of 8.311.3.11 NMAC above, it will still be entitled to receive payment for any quarter yet remaining in the prospective payment year, after acceptable information has been submitted. However, payments to untimely reporting facilities will be limited to the amount of funds that remain available under the upper limits described in Subsection D of 8.311.3.11 NMAC, after prospective payment amounts to timely filing facilities have been established.

[8.311.3.12 NMAC - Rp, 8.311.3.12 NMAC, 6/1/2016]