


# Graduate Medical Education Expansion in

# New Mexico Five Year Strategic Plan

December 2019

## I. Executive Summary

Expansion of the healthcare workforce is an urgent need in New Mexico (NM). It is a priority of Governor Michelle Lujan Grisham and is included in the Human Services Department (HSD) strategic plan. It also is a priority of the legislature as demonstrated by the passage of House Bill (HB) 480 in 2019, which established the Graduate Medical Education (GME) Expansion Grant Program to create and expand primary care[1] physician residency programs as well as a governing body to oversee the program.

The GME Grant Expansion Program is an important step in addressing physician shortages in NM. GME is the physician training period after medical school and before independent practice; and, research illustrates 50-75% of residents will stay within 100 miles of their residency program. Physician shortages exist across all specialties in NM, creating challenges in healthcare delivery, quality, and access. An older physician population, an aging population, and the fact that 29 of New Mexico's 33 counties are rural or frontier further exacerbates these challenges.

Investment in the primary care physician workforce yields significant returns for both local economies and population health. For example, each physician supports $3,166,901 in output, an average of 17.07 jobs, approximately $1.4 million in total wages and benefits and $126,000 in state and local tax revenues. The primary care physician workforce propels economic growth in other aspects of the healthcare system as well, generating $784,752 in direct, billed charges for a hospital and $241,276 in professional fees for the other specialty consultants. Finally, the availability of a primary care physician in a rural area leads to better health outcomes such as those relating to mortality and heart disease as well as a reduction in emergency room visits.

This five-year strategic plan outlines a thoughtful, achievable, and bold plan to increase access to healthcare by using informed and innovative strategies to develop and expand accredited primary care and psychiatry GME programs to improve the health of New Mexicans. This expansion builds on commitments from programs, state agencies, and the legislature. **During the next five years it is anticipated GME primary care programs will grow from 8 to 13 (63% increase). Additionally, the number of primary care residents in training will grow from 142 to 268 (89% increase) and the number of graduates each year will grow from 48 to 84 (starting in 2025), representing a 75% increase.**

This growth requires an annual investment of ~$1.14 million in state general funds over five years, and HSD is committed to leveraging all federal funds available. Furthermore, the 126 additional residents will generate an estimated $399 million in economic output and an average of 2,150 jobs. If achieved, New Mexicans will have more timely access to community driven, culturally informed primary care and behavioral health services, through growth of high-quality GME primary care training programs.

[1] There are many definitions of primary care. For the purposes of this strategic plan, primary care includes the following specialties: Family Medicine, General Internal Medicine, General Psychiatry, and General Pediatrics.

## II. Background and Introduction

House Bill (HB) 480 (Graduate Medical Education Expansion Grant Program Act) charges HSD to establish a GME grant program designed to develop new or expanded GME programs (the physician training period after medical school and before independent practice) focusing on the specialties of general psychiatry, family medicine, general pediatric medicine, and general internal medicine. Enacted with broad bipartisan support, the statute prioritizes expansion of primary care physician training in rural and underserved communities. The statute also creates a governing body to oversee the grant program and make grantee recommendations to the HSD Secretary. This strategic plan was developed by the GME Expansion Review Board (Board), Advisory Group, and the HSD Secretary and Board Chair have approved this plan for publication.

HSD has provided funding to GME programs for decades through the Medicaid program.[2] However, the majority of GME funding in the United States comes from Medicare.[3] Historically, the University of New Mexico (UNM) Medical Center has been the predominant GME training institution in NM. Beginning in 1996, other hospitals began residency programs as a result in changes to federal Medicaid regulations. More recently, there have been initiatives to establish additional GME programs in other settings such as community hospitals, and Federally Qualified Health Centers (FQHCs). The expansion of GME programs in these other settings has been successful, in part, because of the New Mexico Primary Care Training Consortium (NMPCTC), which was established in 2013 to assist community-based organizations in the development of GME residency programs.

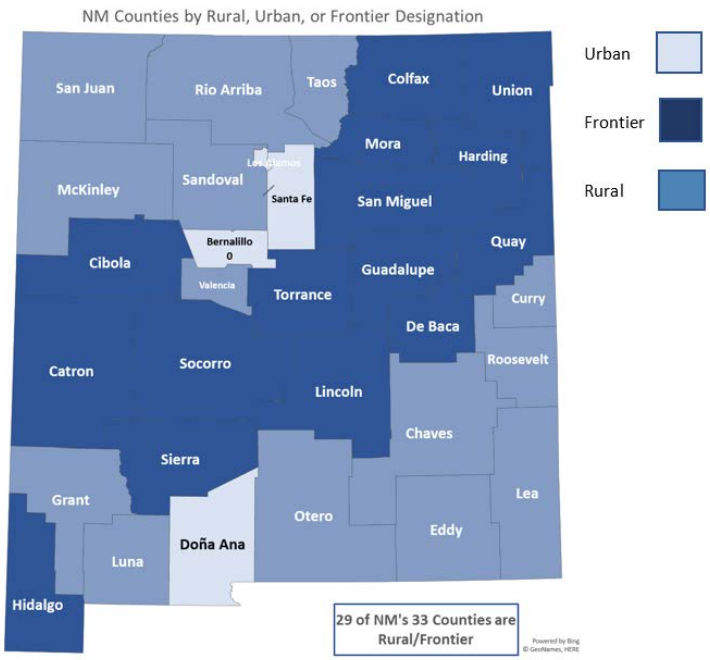
The need for primary care providers in NM and nationally is well documented; and, this need remains on-going and will exist well into the future. Physician shortages exist across all specialties, creating challenges in healthcare delivery, quality, and access. Furthermore, NM has the oldest physician population, a shortage of providers particularly in rural and frontier communities, and an on-going need for 100 –200 primary care physicians and a similar number of psychiatrists. Thus, the ability to serve Medicaid beneficiaries and others in a comprehensive, cost-effective primary care system is significantly hampered by this provider shortage.

## III. New Mexico Overview

Prior to their encounter with the Spanish in 1540, the Anasazi, Pueblo, Navajo, Ute, Jicarilla, and Apache communities resided in the land in what is today known as New Mexico. Today, the state has a population of 2,103,586 residents, with more than 60% identifying as racial or ethnic minorities. Two-thirds of the population live in the state's six most populous counties, with an average population density of 6.9 persons/square mile in the remaining 27 countries. This low population density combined with long distances make the provision of healthcare particularly challenging. Furthermore, the percentage of state residents aged 65 or older was 16.5% in 2016

[2] A joint federal and state program that helps with medical costs for some people with lower-incomes and limited resources. Medicaid programs vary from state to state.
[3] The federal health insurance program for: people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease.

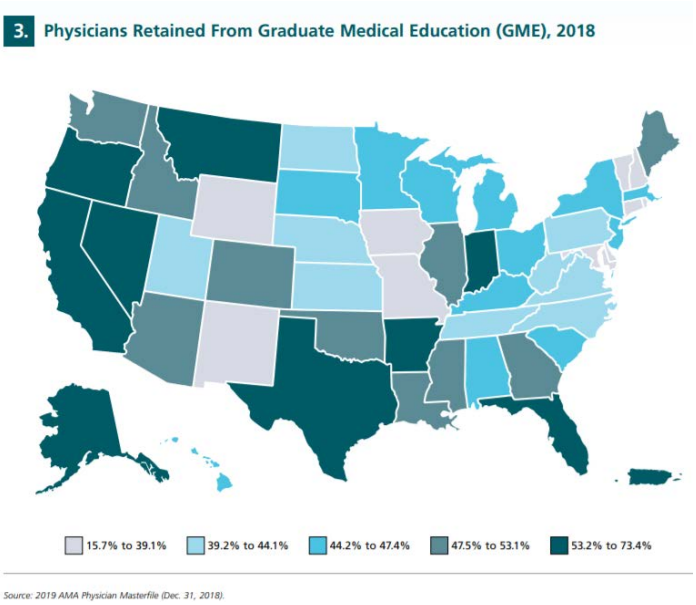
and the rate of growth is outpacing most states. Finally, half of the population is on public health insurance, with 10 counties having 47-68% of all residents identified as Medicaid beneficiaries.




In many health and socioeconomic indicators, NM fares worse when compared to other states. In 2017, the percentage of persons living in poverty was 19%, with many counties experiencing higher than average percentages of food insecurity. The state's life expectancy decreased even more than that of the US in 2016- by 0.3 years. Although NM has lower death rates than the national average for heart disease and cancer, it has much higher death rates for unintentional injuries, specifically overdose, motor vehicle injuries, and falls. NM also has significantly higher death rates than the national average for suicide, cirrhosis, and chronic liver disease.

## IV. Graduate Medical Education: Return on Investment in New Mexico

Research illustrates 50-75% of residents will stay within 100 miles of their residency program. In Family Medicine, specifically, 55% of residency graduates practice within 100 miles of their training location. In NM, between 30-39% of all physicians (regardless of specialty) remain in the state after residency. Increasing retention is critical, because investments in primary care GME yields significant returns for physicians-in-training, local economies, and population health; and, is compounded by increases in retention.




*Return on Investment: Residents & GME Programs*

For residents, the impact of GME programs goes well beyond the biomedical knowledge and experience imparted through residency curriculum. Because GME programs disproportionately serve medically underserved communities, GME programs are a primary opportunity to instill in

health professionals a social conscience and dedication to care. More than 50% of safety net healthcare services are provided by GME training programs.

Institutions that pursue GME programs realize several other advantages. GME residency programs create a culture of learning and an environment of inquiry, promote resident retention in the community, increase productivity in care delivery (a precepting physician can supervise up to 4 residents), and provide vital financial reimbursement that support the teaching mission. In addition to providing patient care (including inpatient and outpatient care, emergency care, rapid response teams, and acute and chronic health problem management) residents often are the catalyst for the adoption of new technology in healthcare and medicine, advancing residency programs. Finally, many residency programs recognize the value in retaining residency program graduates within their health systems, because it substantially reduces recruitment costs.

*Return on Investment: Local Economies*
The economic value of increasing the primary care workforce can be considered in several ways. For example, the direct and indirect economic impact of physicians can be estimated across medical revenues generated during patient care (output), jobs, wages and benefits, and state and local tax revenue. The direct impact is calculated from physician activity, the indirect economic impact from the industries supported by physicians. On average each physician supports $3,166901 in output, an average of 17.07 jobs, approximately $1.4 million in total wages and benefits, and $126,000 in state and local tax revenues.

The cost of supporting a primary care clinic is likely to be more than offset by the revenues generated from the use of hospital and referral services by patients who receive care in primary care settings. A study of the economic impact of a family practice clinic illustrated that for every $1 billed for ambulatory primary care, there was $6.40 billed elsewhere in the healthcare system. Each full-time equivalent family physician generated a calculated sum of $784,752 in direct, billed charges for local hospitals and $241,276 in professional fees for other specialists. Finally, a full accounting of the benefits of GME programs also include contributions made by the residents' spouses, partners, and other family members.

*Return on Investment: Population Health*
The availability of a primary care physician in a rural area has been shown to lead to better health outcomes such as those relating to all-cause mortality (including cancer), and heart disease. Furthermore, an increase in one primary care physician per 10,000 individuals results in: 1) an 11% decrease in emergency room visits; 2) 6% decrease in hospital inpatient admissions; and, 3) 7% decrease in surgery utilization. These improvements persist after controlling for sociodemographic characteristics. Ultimately, people who identify a primary care physician as their primary source of care are healthier, regardless of health status or demographics.

## V. Graduate Medical Education Expansion Grant Program Act Purpose

Pursuant to HB 480, the Board and HSD are tasked to award grants that:

- establish new GME training programs;
- expand number of first-year positions within an existing GME training program; and,
- fund existing GME training programs.

The Board and HSD also are tasked to create a 5-year, statewide GME expansion strategic plan that prioritizes the following types of development and expansion efforts:

- new or expanded primary care GME program development;
- increasing residency positions for medical specialties having shortages within the state, with preference being given to the primary care specialties of family medicine, general psychiatry, general pediatric medicine, and general internal medicine; and,
- increasing primary care residency positions in medically underserved areas.

To accomplish these goals, the Secretary has appointed a Board and an Advisory Group, composed of state officials, GME primary care program administrators and staff, primary care providers, and primary care residents/recent graduates.

## VI. Goals of the Graduate Medical Education Expansion Review Board & Advisory Group

**Mission:** To increase access to healthcare by using informed and innovative strategies to develop and expand accredited primary care and psychiatry graduate medical education to improve the health of New Mexico.

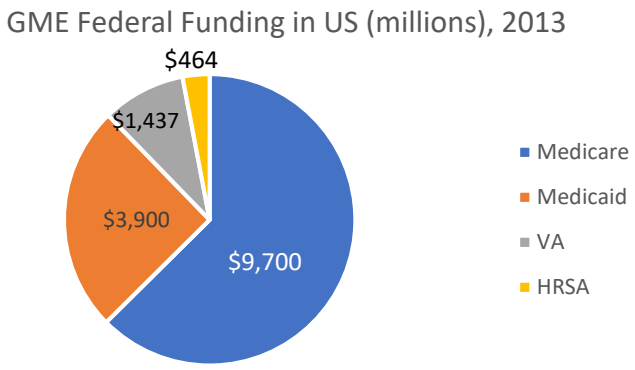
**Vision:** All New Mexicans have timely access to community driven, culturally informed primary care and behavioral health services, through growth of high-quality graduate medical education training programs.

**Goals**

- Create a comprehensive 5-year plan for GME expansion state-wide to significantly increase the number of primary care, psychiatry, and other high need training programs.
- Develop and implement a grant evaluation and award process for the development and expansion of nationally accredited residency programs.
- Develop a financing and program support plan for sustainable program expansion.

## VII. Graduate Medical Education Financing in New Mexico

GME is financed by a variety of public (and some private) funds. The distribution of federal GME funding in the United States is presented at right. Most GME federal funding is provided by the US Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS), followed by funding from the Veterans Administration (VA), and finally HHS Office of Health Resources and Services Administration (HRSA). This pattern holds true in NM as well, where CMS is the largest source of GME financing in the state. The table below outlines GME financing in NM for Fiscal Year (FY) 2019.



| GME Financing in New Mexico (FY 2019)[4] | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Funding (in millions) | | | | | | |
| Sponsoring Institution | Full Time Employee | Medicare | | Medicaid | | HRSA | VA | Private |
| | | IME | DGME | IME | DGME | | | |
| UNM | 459.75 | $22,458.5 | $7,079.2 | $80,883.1 | $6,800.9 | $0 | $0 | $0 |
| Mountain View Medical Center | 12 | $.54* | unknown | $0 | $0 | $0 | $0 | $0 |
| Memorial Medical Center | 18.04 | $.79* | $.57* | $0 | $.60 | $0 | $0 | $0 |
| UNM & Christus Saint Vincent | 9.53 | $.64 | $.46 | $0 | $.33 | $0 | $0 | $.07 |
| Hidalgo Medical Services, Silver City | 6 | $0 | $0 | $0 | $0 | $.90 | $0 | $0 |

*Medicare*

As the primary finance vehicle for residency programs in the United States, Medicare greatly influences the ability of organizations to develop GME programs. Generally, Medicare rules and regulation permit the reimbursement of hospitals and other organizations through two payment mechanisms: Indirect Medical Education (IME) and Direct Medical Education (DGME) payments. A qualifying institution can receive either or both forms of payment. The former is paid to only hospitals, which acknowledges the incremental costs of training residents in hospital settings. DGME is paid to reimburse hospitals and other organizations for resident and faculty salaries, as well as other direct training costs.

Medicare has been the foundation for GME financing for more than six decades in the US and NM. Yet, Medicare rules have limited and inhibited residency growth in several ways:

- In 1997, Congress placed a cap or upper limit on the numbers of residents it would fund to contain healthcare costs. As a result, for nearly 25 years, many organizations in NM such as Memorial Medical Center, St. Vincent Hospital, and Presbyterian Healthcare Services are capped and unable to solicit additional Medicare GME funding.

- The amount of money received by a residency program for direct costs associated with training a resident is called the Per-Resident Amount (PRA). Medicare rules sometimes result in a PRA payment of $0 (zero) per-resident if the GME Sponsoring Institution (SI) does not claim a rotating resident on their cost report. This phenomenon occurs when a resident first rotates to a hospital, which triggers the hospital's cap-building period. When this period concludes, the hospital is then left with the cap and a PRA of $0, because no cost was associated with the training of that resident in its Medicare cost report.

[4] Figures with * reflect FY 2016.

*Medicaid*
The structure of hospital GME funding under Medicaid in NM is like Medicare in that it includes both IME and DGME. Beginning January 2019, Medicaid IME funds became available to every hospital in the state with an approved residency program. (Prior to that time, only UNM Hospital was eligible). Medicaid IME compensates hospitals for residency training costs through quarterly Fee-for-Service (FFS) payments, determined by the maximum amount of FFS payments a hospital can receive (also known as the Upper Payment Limit (UPL). FFS payments are a separate payment that helps hospitals serve needy populations and part of the Disproportionate Share Hospital (DSH) payment methodology. FFS payments are not part of the hospital Medicaid managed care patient billing system

Like Medicaid IME payments, Medicaid DGME funds are sent to hospitals via quarterly FFS payments. Current Medicaid DGME funds are insufficient to capture the costs of residency training (2018 NM DGME funds averaged ~$34,000 per resident). The amount of DGME funding is determined by: 1) type of resident; 2) a hospital's UPL; and, 3) the annual limit in total DGME spending set by HSD (currently $18,500,000).

A task of HSD, with input from the Board, is to develop a payment model that encourages primary care residency development by assuring Medicaid IME and DGME payments more fully cover training costs. The Centennial Care 2.0[5] waiver application included a discussion of improving GME payments for these purposes and may pave the way for future regulatory changes.

*Teaching Health Center Graduate Medical Education Program*
The Affordable Care Act established the Teaching Health Center Graduate Medical Education (THCGME) program. Administered by HHS HRSA, the THCGME program provides grant funding and technical assistance to new and expanded primary care medical and dental residency programs in community-based primary care settings, such as FQHCs, rural health clinics, and tribal health centers. In FY20, the program provided DGME funding of $150,000 per-resident per-year. Congress reauthorizes the program, including funding levels, every other year. Since 2011, the THCGME program has supported the training of more than 880 new primary care physicians and dentists. In the 2018-2019 academic year, the THCGME program supported the training of 728 residents in 56 primary care residency programs across 23 states. The most frequently represented discipline is family medicine (65%).

*Veterans Administration*
In 2014, the Veterans Access, Choice and Accountability Act provided an increase of 1,500 GME residency positions at its medical facilities. Currently the VA funds approximately 10,300 GME positions nationwide through which 40,000 individual residents rotate. Although the VA participates in more than 2,600 GME residency programs, it prohibits its facilities as functioning as SIs. Thus, the VA is dependent upon other SIs to expand GME residency programs into VA facilities. The only VA hospital in NM is in Albuquerque, which supports 122 residents through 33 training programs. The Albuquerque VA is a potential funding source for new residents that the Board, Advisory Group, and HSD will continue to explore.

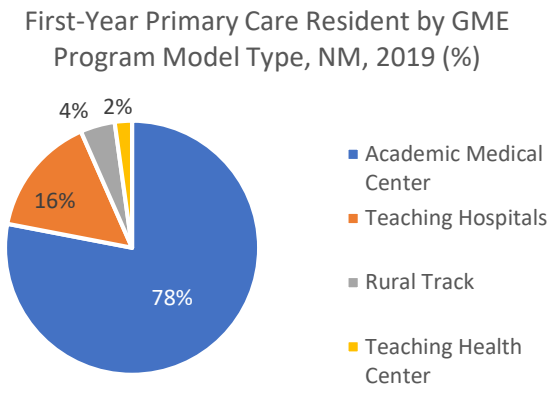
[5] Centennial Care 2.0 is the name of the Medicaid program in NM.

*Sponsoring Institution Support*
A SI is the organization (or entity) that assumes the ultimate financial and academic responsibility for a GME program consistent with the Accreditation Council for Graduate Medical Education (ACGME) institutional requirements. The SI has the primary purpose of providing educational programs and/or health care services (e.g., a university, a medical school, a hospital, a consortium). All SIs support residency programs directly and through revenues generated by residency programs. For example, UNM Hospital capitalizes on its status as a public university to leverage CMS funds by paying an intergovernmental transfer (IGT), which allows them to receive matching federal funds from CMS. In FY19, UNM Hospital paid nearly $30 million in IGTs to Medicaid.

*Private Philanthropy*
Some programs have identified and solicited funding from private organizations and NM hopes to take advantage of this as well. Private support could take the form of student scholarships or other GME costs to expand the number of residents.

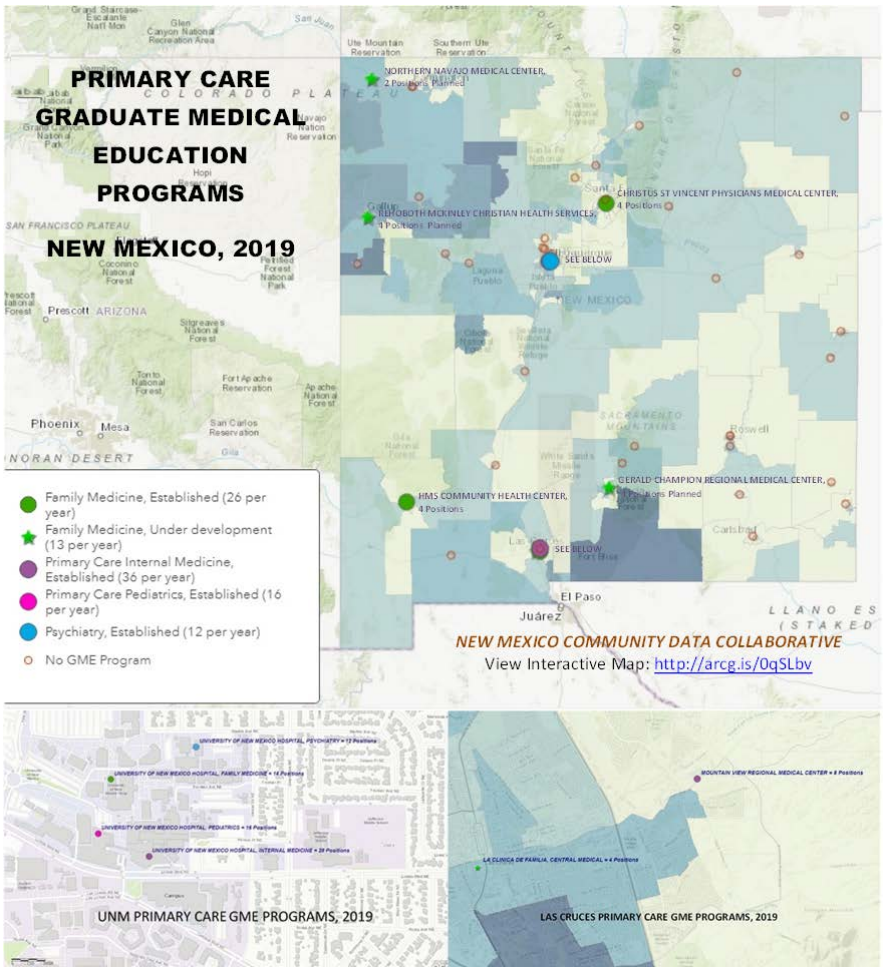
## VIII. Current Graduate Medical Education Program Models in New Mexico

Because residencies are post-medical school programs, they may or may not be directly affiliated with a medical school. The UNM School of Medicine has served as the primary GME SI in NM. Other models that exist including teaching hospitals, Rural Training Tracks, and FQHCs, which are explored in further detail. A map outlining the eight current primary care GME programs in NM is displayed to the right. Together, these programs currently provide training to 90 first-year primary care residents, as illustrated by the pie graph below.[6]




*Academic Medical Center*
An Academic Medical Center (AMC) consists of three related elements: 1) a medical school that trains physicians; 2) research activities; 3) and, a system for delivering healthcare services. According to the Association of American Medical Colleges (AAMC), there are ~120 AMCs in the US. UNM Hospital is the only AMC in NM.

[6] This calculation reflects all first-year residents in primary care specialties as defined by the GME Review Board & Advisory Group. Adjustments to this number were made to account for the fact that roughly 40% of pediatric residents and 10% of internal medicine residents will enter primary care post-residency.




| GME Training Model: Academic Medical Center | | | |
|---|---|---|---|
| UNM Primary Care Specialty | Number of First-Year Residents (2019) | Residents Entering Primary Care (%) | Notes |
| Family Medicine | 14 | 95% | - |
| Internal Medicine | 28 | 10% | A primary care track is available, which an average of 2 residents per-year select |
| General Pediatrics | 16 | 40% | ~40% of Pediatric residents select primary care upon completion of residency |
| General Psychiatry | 12 | N/A | Psychiatrists provide primary care services often as consultant liaisons and via telehealth. Those who do fellowships in geriatric, child, or addiction psychiatry may also provide primary care services |

*Teaching Hospitals*

A Teaching Hospital operates one or more ACGME accredited residency programs. The Teaching Hospital is usually also considered the SI for all residency programs within the hospital. It may have formal or informal relationships with medical schools but it is not required

to be owned by- or directly affiliated with- a medical school. Most GME residency programs are based in Teaching Hospitals (AAMC estimates ~1,100 Teaching Hospitals in the US). Examples of Teaching Hospital-GME programs in NM are those operated by Memorial Medical Center, and Mountain View Regional Medical Center in Las Cruces.

| GME Training Model: Teaching Hospitals | | | | |
|---|---|---|---|---|
| Program | Primary Care Specialty | Number of First-Year Residents (2019) | Residents Entering Primary Care (%) | Notes |
| Mountain View Medical Center | Internal Medicine | 8 | Unknown | No graduates yet. |
| Memorial Medical Center | Family Medicine | 6 | Unknown | - |

*Rural Training Track*

Traditionally, the Rural Training Track (RTT) is has been a program within a Teaching Hospital or Academic Medical Center structured to allow residents to train in an urban setting for a portion of residency to ensure training in subspecialty care. The remaining years of residency are performed in a rural or off-site setting with approval of the urban SI. Since the model's inception, RTTs have evolved so that nearly all years of residency can be performed in a rural area, with necessary rotations in urban areas to ensure compliance with accreditation standards. RTTs are accredited as separate programs by the ACGME and require their own Program Director and faculty.

There is one RTT in NM, where Family Medicine residents spend their first year at UNM in Albuquerque and their second and third years at CHRISTUS Saint Vincent in Santa Fe. A second RTT has been approved at Gerald Champion Regional Medical Center in Alamogordo with Memorial Medical Center in Las Cruces serving as its SI and first year residency location. The program will accept residents beginning summer 2020.

Hidalgo Medical Services in Silver City is a unique model in that it is a RTT. Hidalgo Medical Services is a frontier, independently-accredited FQHC-based GME program that serves as its own SI and is partnered with an urban hospital (Memorial Medical Center) that acts as its first-year experience. Hidalgo Medical Services also is financed through the THCGME program.

| GME Training Model: Rural Training Track | | | | |
|---|---|---|---|---|
| Program | Primary Care Specialty | Number of First-Year Residents (2019) | Residents Entering Primary Care (%) | Notes |
| UNM & CHRISTUS Saint Vincent | Family Medicine | 4 | 70% | UNM is the SI. |

*Teaching Health Centers*

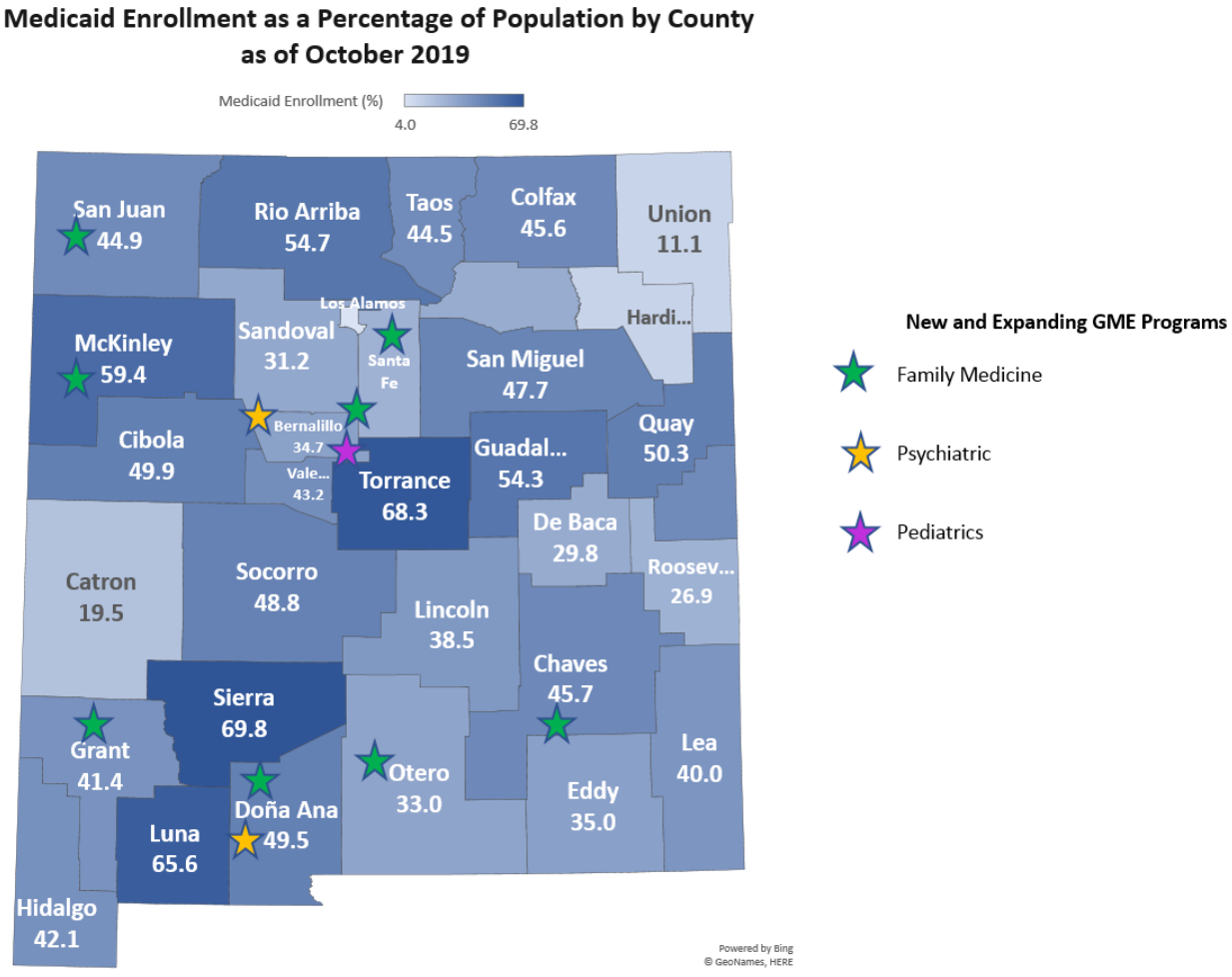
As mentioned previously, the THCGME provides grant funding and technical assistance to new and expanded primary care medical and dental residency programs in community-based primary care settings, such as FQHCs, rural health clinics, and tribal health centers. Hidalgo Medical

Center (a FQHC located in Silver City) is the only residency program receiving THCGME funding in NM.

| GME Training Model: Teaching Health Center | | | | |
|---|---|---|---|---|
| Program | Primary Care Specialty | Number of First-Year Residents (2019) | Residents Entering PC (%) | Notes |
| Hidalgo Medical Services | Family Medicine | 2 | 100% | - |

## IX. Graduate Medical Education Programs under development or considering expansion in NM

Over the last several years, with support from state and federal funding, the NMPCTC, and the legislature, several residency programs have begun development or expansion in NM. As the figure illustrates, these programs target areas with high proportions of Medicaid beneficiaries. Following is a map and a table of residency programs under development as of October 2019.



| GME Programs Under Development or Considering Expansion in New Mexico | | | | | | | |
|---|---|---|---|---|---|---|---|
| SI | New/ Expansion | Partner/ (Location) | Model | Specialty | Annual Resident Capacity | Status | Notes |
| Rehoboth McKinley Christian Hospital | New | Independent (Gallup) | Teaching Hospital (TH) | Family Medicine (FM) | 4 | 2021 start | SI approved, application under development |
| UNM | New | N. Navajo Medical Center (Shiprock) | RTT | FM | 4 | Unknown | Early Development |
| UNM | Expansion | CHRISTUS (Santa Fe) | RTT | FM | 2 | Unknown | Early Development |
| Memorial Medical Center | New | Gerald Champion RMC (Alamogordo) | RTT | FM | 3 | Possible 2020 start | ACGME approved |
| Memorial Medical Center | Expansion | La Clínica de Familia (Las Cruces) | THCGME | FM | 4 | Possible 2020 Start | Application submitted for Continuity Clinic |
| Hidalgo Medical Services | Expansion | Silver City | RTT | FM | 1 | Possible start 2021 | - |
| UNM | Expansion | Albuquerque | AMC | IM | 3 | 2020 | ACGME approved |
| UNM | Expansion | Albuquerque | AMC | Pediatrics | 5 | 2020 | ACGME approved |
| UNM | Expansion | Albuquerque | AMC | Psychiatry | 3 | 2020 | ACGME approved |
| Memorial Medical Center | New | Las Cruces | Teaching Hospital | Psychiatry | 3 | Possible 2022 start | Early Development |

## X. Potential Graduate Medical Education Programs in New Mexico

This strategic plan highlights communities in the state that may have the capacity or willingness to develop new residency programs soon. There may be others interested that were not identified and not all collaborative partnerships can be predicted. Following is a chart indicating what communities and or organizations might consider primary care residency development.

| Potential GME Programs in New Mexico | | | | |
|---|---|---|---|---|
| SI | Location | Model | Specialty | Rationale |
| Eastern NM Medical Center & Burrell College | Las Cruces | Unknown | FM | Southeastern NM has no GME programs |
| UNM Rural | Unknown | AMC | Psychiatry | NM has significant shortages and limited availability of BH services |
| Presbyterian | Unknown | Unknown | FM | Clinical capacity and potential for specialty exposure exists |

| | | | | |
|---|---|---|---|---|
| Lincoln County Medical Center | Not decided | Not decided | FM | Lincoln County has a shortage of physicians. Community is in early exploration |

HSD and the NMPCTC are in conversations with these programs to determine interest and will continue engagement to determine the feasibility to develop new- or expand existing- primary care GME residency programs.

## XI. Summary of Graduate Medical Education Expansion in New Mexico

When considering the totality of GME expansion proposed in this strategic plan, NM intends to make significant strides in expanding the primary care physician workforce. **During the next five years it is anticipated GME primary care programs will grow from 8 to 13 (63% increase). Additionally, the number of primary care residents in training will grow from 142 to 268 (89% increase) and the number of graduates each year will grow from 48 to 84 (starting in 2025), representing a 75% increase.** This growth represents 5 new programs and an addition of 126 residents in training. This expansion represents early efforts with stakeholders expressing interest in developing residency programs.

## XII. Timeline of Graduate Medical Education Expansion in New Mexico

| **5 year timeline of New or Expanded GME Programs in New Mexico**<br>*Number of New First-Year Residents* | | | | | | | |
|---|---|---|---|---|---|---|---|
| Program | FY20 | FY21 | FY22 | FY23 | FY24 | FY25 | **Total Residents** |
| **Family Medicine (3 Year Program)** | | | | | | | |
| Memorial Medical Center & Gerald Champion | 3 | 3 | 3 | - | - | - | **9** |
| Memorial Medical Center & La Clínica | 4 | 4 | 4 | - | - | - | **12** |
| UNM & Shiprock | - | 4 | 4 | 4 | - | - | **12** |
| Presbyterian | - | 4 | 4 | 4 | - | - | **12** |
| CHRISTUS Santa Fe | - | 2 | 2 | 2 | - | - | **6** |
| Rehoboth McKinley Christian Hospital | - | 4 | 4 | 4 | - | - | **12** |
| Eastern NM Medical Center | - | - | 4 | 4 | 4 | - | **12** |
| **General Psychiatry (4 Year Program)** | | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| UNM (expansion) | 3 | 3 | 3 | 3 | - | - | **12** |
| UNM Rural | - | - | 3 | 3 | 3 | 3 | **12** |
| Memorial Medical Center (new) | - | - | 3 | 3 | 3 | 3 | **12** |
| **General Pediatrics (3 Year Program)** | | | | | | | |
| UNM (expansion) | 5 | 5 | 5 | - | - | - | **15** |
| **Total New Graduates Per Year** | **15** | **29** | **39** | **27** | **10** | **6** | **Total new residents trained =126** |

GME expansion will require coordination and planning. Furthermore, new programs typically require 2-5 years for development and existing programs require 1-3 years for expansion. A proposed timeline for GME expansion in NM during the next 5 years is presented below. (Note: General Internal Medicine is not included in the table below as only 10% of IM graduates practice primary care and excluding these programs portrays a more accurate picture of the workforce available to serve as primary care physicians in our communities.)

## XIII. Graduate Medical Education Sustainability in New Mexico

*Programmatic Sustainability*

All residency Program Directors, faculty and staff as well as Designated Institutional Officials, SI GME Committee Chair, and others associated with physician training require on-going education and support. In larger institutions, this can often be a largely internal system of faculty development and ACGME accreditation preparation. However, smaller residencies that are independent of academic medical centers, medical schools, or larger teaching health centers may require on-going support systems to assure accreditation sustainability, faculty development and retention, recruitment assistance, resident collegial support opportunities, quality review services, among other strategies to maintain its program.

The GME Expansion Review Board & Advisory Group recognizes clinical quality, sustainability, and support systems as vitally important. Several years ago, NM family medicine residency programs recognized these conditions and the need to add additional positions and programs. As a result, the NMPCTC was established in 2013.There are several programmatic sustainability issues to consider related to GME expansion in NM, including but not limited to:

- Clinical Sustainability Support
    - ACGME Accreditation Support
        - SI or Program Application development and review
        - ACGME accreditation citation problem solving and maintenance
        - Provide an option for independent umbrella SI for smaller residencies or a consortium of residencies
    - Programmatic and Curricular Support
        - The need for faculty development and support systems in both a single and multi-residency environment

        - Capacity for shared services such as tele-didactics
        - Shared curricula development
        - Evidenced-based and best and promising practices in primary care practice
    - Recruitment and Retention Support
        - Shared resident recruitment processes and recruitment cost
        - Faculty recruitment shared processes and cost
        - Faculty development program and costs sharing
    - Increased Understanding of GME Financing, including Medicare and Medicaid

Through the Board & Advisory Group, HSD recommends on-going assessment and process for determining program sustainability and quality improvement support for developing and operational residency programs. By capitalizing on existing support systems at UNM, the Burrell College of Osteopathic Medicine, the NMPCTC, and residencies themselves, a statewide program addressing residency sustainability priorities can be established. Roles of the Board & Advisory group in facilitating this statewide academic network could include an annual assessment of PC SI and residency program needs that include: 1) staffing needs; 2) ACGME technical assistance; 3) faculty development; 4) financial needs; 5) recruitment support needs; best and promising practices in resident education and management; and, 6) other issues as identified by the programs.

*Financial Sustainability*
When compared to Medicare rules and regulations, CMS has fewer governing statutory or regulatory restrictions on states seeking federal Medicaid matching support for physicians training. State government and Medicaid support of residency development is critical to assuring the financial viability of existing and future residency programs in NM. Residency costs are estimated at $160,000- $180,000 per-resident per-year (and likely higher for certain specialties like psychiatry). Although other sources of residency support exist, public financing via Medicare and Medicaid remain the most stable and consistent sources of financing.

Nevertheless, current state Medicaid rules place an additional cap on the number of residents and the amount residency programs may receive in DGME funding. Specifically, the total number of residents Medicaid will support in NM is 450 (~437 residents were financed in FY19). The remaining 13 positions would be filled by 4 new residents per-year in one three-year program. This projected growth falls short of the number of residents proposed for development.

In addition, payments for DGME are divided into three categories of support: rural residencies, primary care residencies, and all other residencies. In the current rules, primary care residencies receive the lowest amount of DGME support; and, are available to hospitals serving at least 5% Medicaid patients. These funds reflect ~25%-33% of actual DGME costs incurred by programs. Furthermore, there is an annual limit of $18.5 million on the amount of DGME that can be provided via Medicaid. As a result, the financing of the current number of residents approved for support exceeds the funds available, meaning each residency program receives less than its target as defined in the rules. In addition, FQHCs resident training costs- a separate part of the GME payment systems- have not been adequately addressed under current state rules.

*Key Medicaid GME Payment Considerations for Primary Care GME Expansion in New Mexico*

- Current Medicaid DGME payment rules support sub-specialty training at a 25% higher rate of reimbursement than primary care residencies. To promote primary care GME residency program, HSD will explore modifying current DGME rates to significantly favor primary care and/or rural residencies. The Department will also explore combining rural and primary care categories as a method to streamline primary care funding.
- There is currently a cap of 450 on the number of residents approved for GME support through Medicaid. This plan adds 126 residents over the next 5 years. These projections do not include other specialty programs that might be developed in the same period. Assuming additional growth, the overall threshold for residency positions would be close to or exceed 600 total residents.
- HSD will explore amending the annual limit ($18.5 million) on DGME payments to reflect the full amount reflected in the New Mexico Administrative Code (NMAC) for existing and anticipated primary care residency growth.
- HSD will explore addressing hospital FFS payments and UPLs as it relates to GME. GME payments are included in determining a hospital's UPL; and, if a hospital is at its limit, it may not benefit from GME expansion. HSD will explore the feasibility of creating an exemption to the UPL for GME payments or creating a separate category of FFS payment specifically for GME.
- HSD will promote that Medicaid GME payments stay with the resident rather than the facilities. This will encourage other sites- particularly in rural and underserved areas- to hosts residents and provide the financial capability to accommodate residents.

## XIV. Criteria for Consideration for GME Expansion Grant Program

HSD will prioritize grant applications that emphasize the following: (1) developing new or expanded programs with specialties of general psychiatry, family medicine, general pediatric medicine, and general internal medicine; (2) increasing positions for medical specialties having shortages within the state; and, (3) increasing positions in medically underserved areas.

Any of the entities below may apply for GME Expansion Grants:

- a NM SI;
- a NM licensed hospital;
- an academic medical education institution;
- a new or proposed freestanding GME program;
- an established or new GME training consortium; or,
- a FQHC or Rural Health Clinic.

An eligible GME program must meet the criteria below. The program must:

- be an existing, new or planned, nationally accredited non-military residency (post-medical school GME) program;
- be an SI;
- have, or intend to have, first-year residency positions; and,
- intend to create new first-year positions through expansion of an existing program or establishment of a new GME program.

Preferences for grant funding include:

- FQHC applicants;
- Applicants providing services in rural or frontier communities; and,
- Providers operating in underserved communities (e.g. disparate access to primary care, poor health status, racial and ethnic health disparities).

## XV. Stakeholder Engagement

*Community Initiated Opportunities for Development*
HSD will distribute correspondence to all healthcare provider entities eligible for primary care residency GME residency development in 2020. Interested parties will be instructed to contact HSD and the NMPCTC contractor. Follow up visits to explain programs and opportunities will occur as soon as possible.

*State Summit on Residency Development*
Also in 2020, HSD will host a Statewide Summit on GME primary care residency development. The purposes of the Summit will be to:

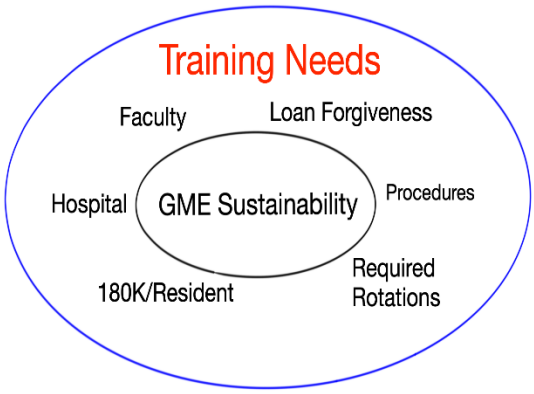
- Review the State Strategic Plan for GME primary care expansion;
- Review eligibility requirements for public and private GME financing, including Medicare, Medicaid, THCGME;
- Review GME Medicare and Medicaid GME Financing Regulations;
- Identify organizations interested in new or expanding residency development; and,
- Explore ways by which interested organizations can solicit GME Expansion Grant funding.

## XVI. Call to Action

New Mexico has a shortage of all types of providers - both primary care physicians and specialists. The urgent need for healthcare providers and the impending crisis in the healthcare workforce should be publicized to generate community interest in training programs for physicians, advanced practice providers, and healthcare workers at all levels. In addition to increasing the workforce, the participation of this workforce in Medicaid to ensure access to care to those who have been historically underserved is crucial.

The state should work to strengthen access to high-speed communication technologies in rural and frontier communities to improve access to telehealth, as well as expand telehealth to increase the availability of behavioral health services.

GME in the state has historically been structured around organizations, using the hub-and-spoke model with UNM being the hub for most training programs. If GME is to grow and thrive, unique and innovative partnerships should be encouraged. Organizations should be encouraged to view GME as a pipeline for their workforce and realize the economic advantages of increasing the primary care workforce to the healthcare system and to society. Careful consideration should be given to recruitment of residents from rural areas and small towns. These residents, upon graduation, are more likely to remain and practice in areas that have the highest need. The pipeline for training physicians should be structured in a manner that ultimately leads to a workforce that reflects the diversity of people in our state.




Funding and support should be made available to provide technical assistance and faculty development to allow more hospitals to function as Sponsoring Institutions.

An accurate estimation of the workforce requires precise and complete data collection. Redesigning the tools we utilize to obtain this data and enhancing technological capacity to collect this data would facilitate meaningful policy to address community needs.

The long-term success of GME programs is interdependent on various factors, the chief amongst these are stable financing of residents, loan forgiveness for physicians willing to work in rural and frontier areas, and support from the community and academic centers to fulfill academic requirements and facilitate professional development.

## XVII. Graduate Medical Education Expansion in New Mexico- Metrics for Success

The success of GME expansion will be measured by ongoing ACGME accreditation, which includes metrics related to faculty retention, first time pass rate of graduating residents, assessment of resident wellness, and academic standards. Measures of success for NM are highlighted below:

| **GME Expansion in NM Metrics for Success** | |
|---|---|
| Metric | Rationale |
| The number of programs training residents in primary care specialties will double over the course of the next ten years. | The process of creating and maintaining residency programs enhances access to care during residency and encourages retention of physicians in the state. |
| Maintenance of continued accreditation of all new and expanded programs. | ACGME accreditation implies meeting national standards for residency training programs including quality of academic and clinical training program, faculty development and retention, academic |

| GME Expansion in NM Metrics for Success | |
|---|---|
| Metric | Rationale |
| | standards and first-time pass rate of graduating residents. |
| All programs will have 100% fill rates of their programs first year class on July 1 of each academic year. | - |
| All programs will have at least 50% of their graduates remain in NM, and at least 20% serve within 5 years of graduation in rural or underserved areas as defined by communities of less than 35,000 people or counties defined as Health Professional Shortage Areas, or defined by Medicaid patient ratio. | Current overall retention rate is between 39-44%. |
| Development of a statewide faculty training network that will provide academic development opportunities, particularly in rural areas. | The success of rural programs is largely dependent on academic support from larger institutions. |

## XVIII. Acknowledgments

HSD wishes to thank the members of the GME Expansion Review Board & Advisory Group for their contributions to this report, and their dedication and commitment to train future primary care leaders in NM. Report writers include (in alphabetical order): Charlie Alfero (Director, Southwest Center for Health Innovation), Alex Castillo Smith (Strategic Planning & Special Projects Manager, HSD), Holley Hudgins (Director of Workforce Development, Southwest Center for Health Innovation), and Rohini McKee (HSD Policy Fellow; Director of Colorectal Surgery, UNM Health Sciences Center).

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