

HUMAN SERVICES DEPARTMENT



GME EXPANSION REVIEW BOARD & ADVISORY GROUP

DR. DAVID SCRASE, HSD SECRETARY; DR. DAVID RAKEL, BOARD CHAIR

June 4, 2021

INVESTING FOR TOMORROW, DELIVERING TODAY.

AGENDA

Time	Agenda Item	Facilitator(s)	Desired Outcome
10:00	Welcome & Introductions	David	Frame meeting and objectives, provide opportunity for introductions, and establish quorum.
10:05	Federal GME update	Germane Solutions	Update group on federal GME legislative changes, collect comments and feedback from group that will be submitted to CMS as part of formal rulemaking process.
11:15	Board transitions and Spring 2021 applicants updates	Alex	Provide status update on spring 2021 applicants and Board & Advisory Group membership.
11:30	NM Primary Care Council	David	Describe purpose of the Council, membership, and intersections with GME Expansion Review Board & Advisory Group. Explore areas of collaboration.
11:50	Financial Sustainability: Medicaid Update	Erica & Alex	Describe efforts to promote primary care GME sustainability via Medicaid financing.
12:00	Adjourn *Next virtual meeting will be Friday, September 10 (10:00 – 12:00)*		

Federal Updates

June 2021

Confidential DRAFT - For Discussion Only

Agenda

- CMS Proposed Rules for Enacting the Consolidated Appropriations Act of 2021
- MILTON S. HERSHEY MEDICAL CENTER et al v. AZAR II

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CMS Proposed Rule for Enacting Consolidated Appropriations Act

- Refer to Section V.X.2 of the Proposed Rule HR 133 Summary
- Proposed Rule is open for public review and comment at: federalregister.gov/d/2021-08888
- Comment period closes June 26, 2021
- Rule will be enacted on or before October 1, 2021

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Consolidated Appropriations Act: *What We Knew*

Congress passed the Consolidated Appropriations Act, 2021 (HR 133) which provides legislation pertinent to academic medicine with official **enactment date of December 27, 2020**.

Section 126

Application-based distribution of 1,000 Additional Funded FTE over 5 Years

- 200 FTE distributed annually.
- Max of 25 FTE per hospital.
- 40% of positions annually awarded to hospitals in 4 categories: rural, over cap, states with new medical schools, **or** in a HSPA.

Section 127

Promotion of Rural-Urban Partnerships through Accreditation and Financial Incentivization

- Separate RTT accreditation not required as of October 1, 2022.
- Programs maintaining 50% of training in rural area qualify for additional funding.

Section 131

Reset of PRA and/or FTE Cap for Hospitals with FTE less than 1.0 on 1996 report and trained no more than 3.0 FTE since October 1, 1997.

- Available until December 26, 2025
- Participation in Medicare GME Affiliation since enactment date will disqualify the hospital
- PRA will not be established until training 1.0 FTE or more.

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CMS Proposed Rules: *Consolidated Appropriations Act, Section 126*

IN GENERAL

CMS proposes to limit the increase in the number of residency positions made available to each **individual hospital** no more than 1.0 FTE each year, resulting in no hospital receiving more than 5.0 FTE in total.

PROCESS AND TIMELINE

The first application deadline will be **January 31, 2022**

Rural Designation Reclassification deadline for inclusion in application is **January 31, 2022**

First funding disbursement will be **July 1, 2023**

The application is proposed to be comprised of manual data entry, checkboxes, signed and dated attestation letters from financial officials, CMS Cost Report Worksheet Part E, Part A and E-4, and HRSA.GOV confirmed HPSA Scoresheet.

ELIGIBILITY AND LIMITATIONS

Applicable to **both urban and rural hospitals,** CMS proposes to limit the number of residency positions made available to each individual hospital no more than 1.0 FTE each year, resulting in **no hospital receiving more than 5.0 FTE in total.**

CONSIDERATIONS IN DISTRIBUTION

CMS proposes distributing the 200 FTE annually equitably based primarily on category 4, Health Professions Shortage Areas (HPSA). **As proposed, CMS would allocate 1.0 FTE to each hospital with the highest HPSA score, prorating only if the number of hospitals with the highest score exceeds the number of positions available**. CMS proposes continuing in this manner until all available positions are distributed. CMS proposes this does not exclude the other categories; it makes them the lowest priority.

CMS proposes "demonstrated likelihood of filling the additional positions" be met by:

- Submission of CMS Cost Report Worksheet Part E, Part A, and E-4
- Attestation of one or more of the following:
  - ACGME or ABMS new Institution or new Program application submitted by application deadline
  - Is already rotating in residents from an existing program and will use the awarded FTE to accept more residents from the same program.
  - Is already training residents in an sponsored ACGME or ABMS Program and will use the awarded FTE to accept more residents into the program.

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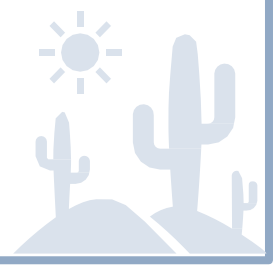
CMS Proposed Rules: *Consolidated Appropriations Act, Section 127*

IN GENERAL

Rural and urban hospital opportunities for collaboration have been strengthened by the removal of the separate accreditation requirement for Rural Training Track (RTT) programs; ultimately allowing **both** rural and urban hospitals to receive federal funding for training programs aimed at increasing the number of physicians in rural areas.

Rural Hospital Funding

CMS is proposing that each time an urban hospital and rural hospital establish an RTT for the first time, even if the program is existing, both the urban and rural hospitals may receive adjustments to their resident caps (e.g., rural track FTE limitations).

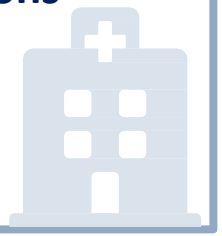


Existing Program Funding

CMS is proposing to **prospectively** allow cap adjustments to hospitals with existing programs and RTTs, but **only when additional residents are recruited to add a new RTT "spoke" to an existing "hub"** for cost reporting periods beginning on or after October 1, 2022.

Beyond Family Medicine

CMS is proposing that effective for cost reporting periods beginning on or after October 1, 2022, so long **as the program is accredited by the ACGME**, regardless of specialty, **it may qualify as a RTT and urban and/or rural hospitals receive rural track FTE limitations** assuming all other requirements are met.



3-Year Average

In addition, CMS proposes to create a rule that allows RTT FTE to be excluded in the 3-year rolling average calculations until the five years of cap development are over for both Urban and Rural facilities.

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ACGME Proposed Process: *Rural Training Programs (RTPs)*

IN GENERAL

ACGME proposes a transition from FM-RTT to a more encompassing program, Rural Training Programs (RTP). RTPs will be a ***designation*** acting like a hybrid between Osteopathic Recognition and RTT accreditation.

DIO opens application and chooses RTP designation request.

↓

Program Director completes and submits the RTP application prior to the full application.

↓

Program Director is notified of outcome prior to completing full application can choose to move forward or abandon.

The ACGME is creating this designation as a method through which new programs can confirm their ability to obtain CMS funding per CAA, Section 127.

This designation is not required for the funding mechanisms proposed in CMS' rule.

For more information, visit: https://acgme.org/What-We-Do/Accreditation/Medically-Underserved-Areas-and-Populations/

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CMS Proposed Rules: *Consolidated Appropriations Act, Section 131 - PRA*

IN GENERAL

This section provides the opportunity to **reset the low or zero direct GME per resident amount of certain hospitals between enactment date and December 26, 2025**. CMS proposes it is not relevant whether hospitals may have trained at least 1.0 or more than three 3.0 before enactment date.

CMS breaks down the proposed rules into two categories, A and B.

CATEGORY		TRAIN AT LEAST
A	As of date of enactment has a PRA that was established based on less than 1.0 FTE in any cost reporting period beginning before October 1, 1997. Typically, a Category A hospital is one that trained less than 1.0 FTE in its most recent cost reporting period ending on or before December 31, 1996 and received a very low or $0 PRA.	1.0 FTE
B	As of the date of enactment has a PRA that was established based on training of no more than 3.0 FTEs in any cost reporting period beginning on or after October 1, 1997, and before the date of enactment.	3.0 FTE

Medicare GME Affiliation Agreements

If YES AFTER ENACTMENT….

CMS proposes to establish a PRA in the instance where a hospital trains <u>less than 1.0 FTE</u>

If NO AFTER ENACTMENT….

CMS proposes to establish a PRA only when a hospital trains at least 1.0 (A) or 3.0 (B), respectively.

The MACs will review cost reports, GME costs, FTE counts, rotation schedules, etc. to determine if the requisite threshold of FTE residents are trained.

CMS proposes the accruing FTE may come from <u>either</u> “new” or “existing” programs.

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CMS Proposed Rules: *Consolidated Appropriations Act, Section 131 - PRA*

Below of examples of these proposed rules' implementation. Note that CMS will not round (up or down) any FTE.

CATEGORY A HOSPITAL

PRA: $0
FTE CAP: 0.72
Medicare GME Affiliation: NO.

Cost Report Period (starting)	Trained FTEs
January 1, 2020	1.25
January 1, 2021	9.89
January 1, 2022	28.22

Because the Category A Hospital's PRA was based on an FTE Cap less than 1.0 FTE, the PRA reset would be based on the first year more than 1.0 FTE is trained.

CATEGORY B HOSPITAL

PRA: $0
FTE CAP: 2.98
Medicare GME Affiliation: NO.

Cost Report Period (starting)	Trained FTEs
January 1, 2020	6.05
January 1, 2021	0.49
January 1, 2022	3.25

Because the Category B Hospital's PRA was based on an FTE Cap less than 3.0 FTE, the PRA reset would be based on the first year more than 3.0 FTE is trained.

CATEGORY B HOSPITAL

PRA: $0
FTE CAP: 2.98
Medicare GME Affiliation: **YES.**

Cost Report Period (starting)	Trained FTEs
January 1, 2020	6.05
January 1, 2021	0.49
January 1, 2022	3.25

Because the Category B Hospital knowingly entered into a Medicare GME Affiliation Agreement after December 27, 2020, **PRA will be set in 2021** even though it's less than 3.0 FTE.

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CMS Proposed Rules: *Consolidated Appropriations Act, Section 131 – FTE CAP*

IN GENERAL

This section provides the opportunity to reset the low IME and direct GME FTE resident caps between enactment date and December 26, 2025 **for hospitals who have <u>not</u> trained Residents from a "new program at some point prior to enactment date."** Cap development would begin the first year the first new program begins through its' fifth year of enactment. CMS also proposes that hospitals with no cap triggered would have no permanent FTE CAP until 1.0 FTE is trained.

CATEGORY		TRAIN AT LEAST	Trained Residents from New Programs	
			If YES BEFORE ENACTMENT….	**If NO BEFORE ENACTMENT….**
A	As of date of enactment has an IME and/or DGME FTE resident cap that was established based on less than 1.0 FTE in any cost reporting period beginning **<u>before</u>** October 1, 1997.	1.0 FTE	The hospital, regardless of low FTE CAP does <u>not</u> qualify for relief.	The hospital may qualify for FTE CAP relief if other requirements are met.
B	As of the date of enactment has an IME and/or DGME FTE resident cap that was established based on training no more than 3.0 FTEs in any cost report period beginning **<u>on or after</u>** October 1, 1997 and before date of enactment.	3.0 FTE		

CMS proposes the accruing FTE must come from <u>only</u> "new" programs.

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CMS Proposed Rules: *Consolidated Appropriations Act, Section 131 – FTE CAP*

The calculations will follow the same methodology as is currently used to determine FTE CAP during cap development periods. This example adds complexity to the former Category A Hospital example to demonstrate when PRA and FTE CAP be reset for a hospital that qualifies for both.

CATEGORY A HOSPITAL

PRA: $0 Medicare GME Affiliation: NO.
FTE CAP: 0.72 Trained New Program Residents Before Enactment: NO.

Trained Resident FTE Type	January 1, 2020	January 1, 2021	January 1, 2022	January 1, 2023	January 1, 2024	January 1, 2025
Existing Program Rotators	1.25	1.25	1.25	1.25	1.25	1.25
Internal Medicine		10.00	20.00	30.00	30.00	30.00
General Surgery				5.00	10.00	15.00
Transitional Year			10.00	10.00	10.00	10.00
		PRA RESET				**FTE RESET**

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Supreme Court Ruling: *Milton S. Hershey Medical Center et al. v Azar II*

IN GENERAL

Hospitals teaching fellows or other learners beyond their initial residency period (IRP) and over their DGME FTE cap have been unlawfully penalized and can request FTE adjustment.

SUMMARY

- This case was a consolidation of 5 separate cases and is regarding the proper weighting of FTEs which only applies to DGME payments.
- The current formula applied through the cost report is often referred to as the "DGME penalty" in that those hospitals that are training residents over their unweighted DGME FTE cap receive a proportional reduction to the weighted FTE counts.

DGME Penalty Example: A hospital capped at 100 FTE and employs 90 residents and 10 fellows:
The calculation is: (100 / 100) x 95 = Weighted FTE of 95.00
But add 10 fellows to this total, thus exceeding the cap: (100 / 110) x 100 = Weighted FTE of 90.91.

- While the court noted that it may be appropriate to adjust the weighted FTEs where a hospital is training residents over their FTE cap**, the court concluded that the way CMS determined that adjustment was in direct conflict with the law and therefore must be overturned.**

TAKE ACTION

Hospitals should protect their appeal rights on all cost reports that are open or unaudited and those audited but within their 3-year reopening period.

It is not yet clear that hospitals will be allowed to reopen audited reports to claim this issue.

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CONSOLIDATED APPROPRIATIONS ACT (HR 133): GME BOARD & ADVISORY GROUP COMMENTS

SEC. 126: APPLICATION-BASED DISTRIBUTION OF 1,000 ADD'L FUNDED FTE OVER 5 YEARS

SEC. 127: PROMOTION OF RURAL-URBAN PARTNERSHIPS THROUGH ACCREDITATION AND FINANCIAL INCENTIVIZATION

CONSOLIDATED APPROPRIATIONS ACT (HR 133): GME BOARD & ADVISORY GROUP COMMENTS

SEC. 131: RESET OF PRA AND/OR FTE CAP FOR HOSPITALS WITH FTE LESS THAN 1.0 ON 1996 REPORT AND TRAINED NO MORE THAN 3.0 FTE SINCE OCTOBER 1, 1997.

FY21 GME EXPANSION FUNDED APPLICANTS

Program	Primary Care Specialty	Location	Funding	New or Expanding Program	First Year Residents	Anticipated Residency Start Date
El Centro Family Health	Family Medicine	Española	$190,823	New	4	2023 (if pursued)
Memorial Medical Center*	Gen. Psychiatry	Las Cruces	$229,475	New	3	July 2022
Christus St. Vincent RMC	Family Medicine	Santa Fe	$190,875	New	3-4	2023 (if pursued)
Total Funds Requested: $611,173						
*Currently receiving Stage 1 GME HSD Funds						

CHANGING MEMBERSHIP

A Fond Farewell:

Dr. David Rakel will step down as a Board Chair this summer.



Welcoming new Board Chair (Sept. 2021)

Dr. John Andazola



Welcoming new Board member (Sept. 2021)

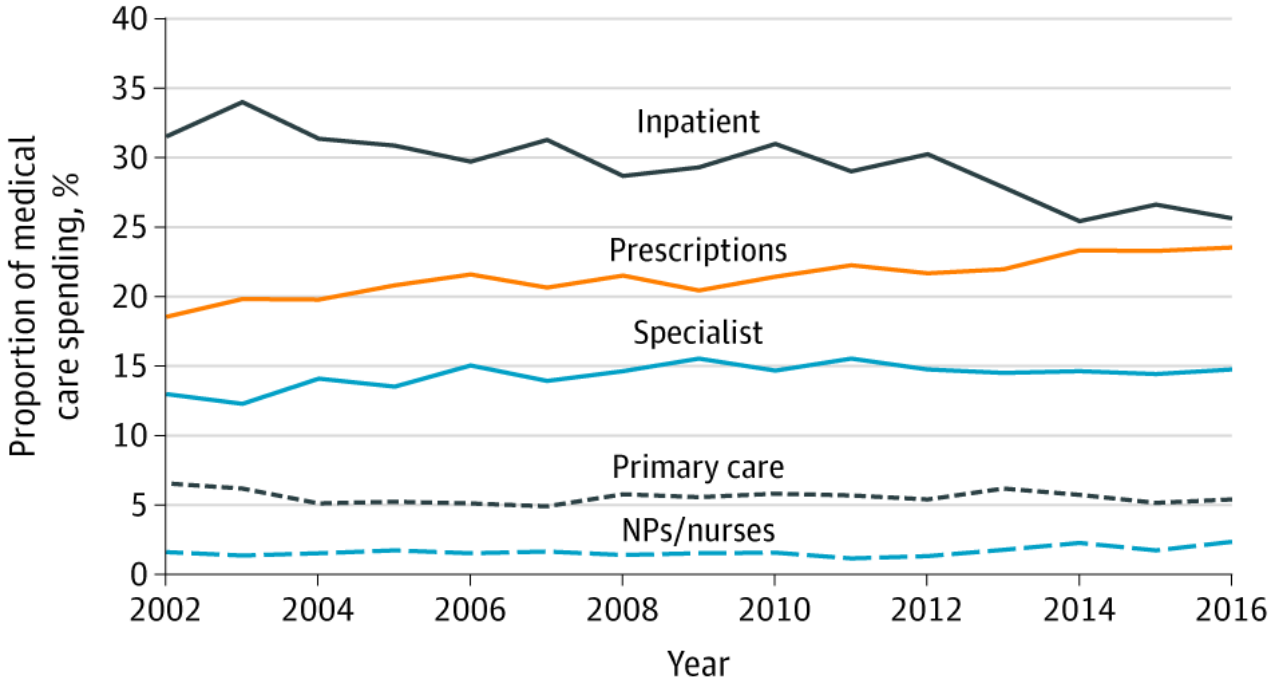
Dr. Val Wangler



NM PRIMARY CARE COUNCIL

- House Bill 67 enacted during 2021 legislative session, established Council to:
  - "Increase access to primary care, improve the quality of primary care services, lower the cost of primary care delivery, address the shortage of primary care providers and reduce overall health care costs" statewide.
- Council consist of 9 voting members representing state agencies FQHCs, and providers.
- Council also include 13 non-voting advisory members "representing healthcare and other stakeholders."
- Among other duties, Council will "coordinate efforts with GME board and other… initiatives to devise a plan that addresses primary care workfare shortages within the State."

Trends in Spending for Select Types of Medical Care, U.S.



Source: JAMA. NP indicates nurse practitioner. Data from Medical Expenditure Panel Survey.

FINANCIAL SUSTAINABILITY: MEDICAID FINANCING

- GME **State Plan Amendment (SPA) approved by CMS on May 25, 2021 with effective date of July 1, 2020.**
  - HSD is working to implement changes and reconcile payments. →
- **1115 Waiver** submitted to CMS on March 1, 2021.
  - HSD engaging with CMS to address questions related to leveraging federal Medicaid funding for program expansion.

Key GME Medicaid Financing Topics

Topic	Current State	Relevance	Solution
1. Raise state annual payment limit to reflect full amount needed for expansion.	Current state Medicaid rules place an annual limit of $19.5 million.	Each resident FTE receives less than its allocated amount (~$34,000).	State Plan Amendment (SPA) removes annual limit.
2. Address FTE limit to reflect full amount needed for existing and anticipated expansion.	Current state Medicaid rules place a FTE cap of 450 for funding.	449 positions filled as June 2020.	SPA removes FTE cap.
3. Increase payment structure to incentivize new Primary Care resident position growth.	State Medicaid rules support a Primary Care FTE at $41,000 while specialist FTEs are funded at $50,000.	New programs cite financial concerns and sustainability as primary barriers towards expansion.	SPA funds new Primary Care FTEs at $100,000. All other new FTE funded at $50,000.
4. Make payments for existing resident FTE positions equitable.	Current state Medicaid rules fund specialties at different rates: • Primary Care: $41,000 • Other: $50,000 • Rural: $52,000	New programs cite financial concerns and sustainability as primary barriers towards expansion.	SPA funds all existing resident FTE (regardless of specialty) equally at $50,000.
5. Amend provider types eligible for Medicaid payments.	State Medicaid rules permit only licensed hospitals with accredited programs.	Non-hospital programs are ineligible for payment.	SPA expands eligibility to FQHCs and RHCs.

FINANCIAL SUSTAINABILITY: MEDICAID FINANCING

- HSD, NM Primary Care Training Consortium, UNM and IHS Shiprock working with U.S. Centers for Medicare & Medicaid Services to determine whether NM Medicaid can provide **Direct GME payments to IHS Shiprock**.
  - Shiprock received ACGME accreditation for program slated to begin in September 2021.
- Federal regulations outline IME typically for inpatient hospitals such as UNM, CHRISTUS, Memorial Medical Center, and MountainView Regional Medical Center.
  - HSD modeling financial impact of expanding Indirect GME payments to free-standing psychiatric hospitals as part of a possible State Plan Amendment.
  - Also exploring expansion of Indirect IME costs for other non-hospital settings (e.g. FQHCs).



HUMAN SERVICES DEPARTMENT



APPENDIX

BURRELL COLLEGE OF OSTEOPATHIC MEDICINE- FAMILY MEDICINE RESIDENCY EXPANSION UPDATE

Goal

- Collaborative effort between La Clínica de Familia, Memorial Medical Center, and MountainView Regional Medical Center.
- To expand the Southern NM family residency program from 18 residents to 30 residents by 2023.
- New residents to begin July 2021.

Program Status:

- Completed agreements between MVRMC with MMC and LCDF to cover costs of additional residents.
- Appointed site directed at LCDF.
- Successfully matched 10 first-year residency positions for July 1, 2021.
- Developed residency schedule for all residents.
- Completed faculty development.

Next Steps

- Sign agreements between MVRMC and MMC/LCDF.
- **Begin residency training.**

MEMORIAL MEDICAL CENTER RESIDENCY UPDATE- GENERAL PSCHIATRY

Goal

- To create a psychiatric residency program in Doña Ana County.
- A collaborative effort between all behavioral health services and providers in the area.
- First-year residents to begin 7/23.

Program Status:

- Contracting with UNM to provide tele-didactics, faculty development and Child/Adolescent rotations.
- Finalizing agreements with Gerald Champion for rotations.
- Coordinating faculty and community meetings for updates and organizing next steps.

Next Steps

- Finalize didactic schedule
- Implement UNM's faculty development plan
- Create recruitment strategy

REHOBOTH CHRISTIAN HEALTHCARE SERVICES RESIDENCY UPDATE- GENERAL PSCHIATRY

Goal

- To create a 2+2 RTT Psychiatric Residency in McKinley County at Rehoboth McKinley Christian Health Care Services with local partners

Program Status:

- Quarter 1 Accomplishments: Hire Program Coordinator; hire consultant; identify rural psychiatry programs in the U.S.; create template of ACGME requirements for tracking; initial outreach to internal and external community stakeholders; outreach to UNM Psychiatric Residency program
- Quarter 2 Accomplishments: Monthly calls with UNM Psychiatric Residency for shared learning; formal meetings with two community psychiatrists to determine interest and appropriateness for participation in psychiatric residency development; outreach to NMPCTC to request development of a Pro Forma, to be available in April
- Initial Quarter 3 Accomplishments: Receipt and review of Pro Forma from NMPCTC; development and posting of Psychiatrist position with role in oversight of medical residents; development of key informant interview questions for community needs assessment

Next Steps

- Implementation of needs assessment
- Formal calls with rural psychiatry programs
- Formal recruitment of a psychiatrist
- Fiscal and operational analysis of RMCHCS behavioral health services

FINANCIAL SUSTAINABILITY: MEDICAID 1115 WAIVER

- To make GME expansion possible, GME programs require funding support from the State.
- **HSD requests expenditure authority for federal match of $500,000 state general fund per year to establish a Primary Care GME expansion funding mechanism designed to develop new and/or expanded GME programs focusing on the primary care specialties of General Psychiatry, Family Medicine, General Pediatrics, and General Internal Medicine.**
- Remainder of waiver language describes expansion program, eligibility for funding, and application process.
- *Amendment Proposal #3 (pages 10-13): GME expansion funding mechanism designed to develop new and/or expanded GME programs focusing on the specialties of General Psychiatry, Family Medicine, General Pediatrics, and General Internal Medicine.*