HUMAN SERVICES DEPARTMENT

STATE OF NEW MEXICO
Michelle Lujan Grisham, Governor
David R. Scrase, M.D., Secretary for Human Services Department
Kari Armijo, Deputy Cabinet Secretary
Angela Medrano, Deputy Cabinet Secretary
Nicole Comeaux, JD, MPH, New Mexico State Medicaid Director

Date: June 23, 2021

To: The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

From: Secretary David R. Scrase, M.D.
On Behalf of the Members of the New Mexico Primary Care Graduate Medical Education Expansion Board & Advisory Group

Re: CMS-172-P; Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2022 Rates

Dear Administrator Brooks-LaSure:

The New Mexico Human Services Department (HSD) appreciates the opportunity to provide comments on CMS-172-P on behalf of the members of the Primary Care Graduate Medical Education (GME) Expansion Board & Advisory Group. Expansion of primary care and expansion of the healthcare workforce is a priority of Governor Michelle Lujan Grisham, the State Legislature, and HSD. Our strategic plan indicates that over a 5-year period (starting in 2019) GME primary care programs will grow from 8 to 13 (63% increase). Over this same period the number of residents in training is expected to grow from 142 to 291 (105% increase). Further, the number of graduates each year would grow from 48 to 94 (starting in 2025), a 96% increase. These and other new program growth mean there will be 46 new primary care and psychiatry physicians graduating yearly, starting in 2025. If we can recruit these doctors to stay in New Mexico, this expanded workforce will serve an additional 100,000 New Mexicans every year.

Together, HSD has been working with community partners such as GME program directors and the NM Primary Care Training Consortium to improve access to primary care and psychiatric services to Medicaid and other underserved populations, through improvements in the Medicaid GME payment and training environment. For example, the Centers for Medicare and Medicaid Services (CMS) in May approved a NM Medicaid State Plan Amendment that will expand primary care training in underserved areas of the state as well incentivize primary care resident training. Additionally, an 1115 Waiver was submitted in Fall 2020 to allow federal matching funds for the purposes of supporting

planning and development of new/expanding programs. We have been working with CMS, Indian Health Service (IHS) and state-based organizations to explore opportunities for Medicaid financing of GME programs in IHS facilities as well such as the Northern Navajo Medical Center in Shiprock, New Mexico. We appreciate CMS' support of these efforts.

The proposed regulations in support of the Consolidated Appropriations Act (CAA) of 2021 provide opportunities for further development of primary care and psychiatric training consistent with the goals of HSD and the Lujan Grisham Administration. Shortages of primary care and behavioral health care professionals, including psychiatrists are addressed better when public policy acknowledges the improvements necessary to disperse scarce provider resources to priority underserved areas. Following is a presentation of our comments:

Regarding Section 126 of the Proposed Regulations

We support proposed language that requires hospitals to demonstrate the likelihood of developing new or expanded GME programs and filling new positions prior to consideration of support from Medicare.

CMS proposes that only hospitals meeting one or more of the following be eligible to apply for new GME slots.

1) Rural hospitals or those with a rural designation
2) Hospitals that are, in summary, "over cap"
3) Hospitals in states with a new medical school or branch such as New Mexico
4) Hospitals in geographic Health Profession Shortage Areas (HPSAs).

We concur with many of the comments sent to the CMS Administrator on June 8, 2021, by "Advocating for Family Medicine" and affiliated primary care organizations, including that the directing of resources to the hospitals most likely to impact primary care access would be greatly enhanced by prioritizing two additional qualifying criteria: 1) small hospitals with less than 250 beds; and 2) hospitals with only one residency program. This would help ensure that Medicare resources would go to places that might not otherwise qualify under the four qualifying criteria above.

We are concerned with the "over cap" criterion in that it may bias financing decisions toward larger hospitals that are more likely to be able to support residency slots more than their cap due to the training of more self-sustaining subspecialty physicians.

Also, since the geographic HPSA designation is based on primary care physician definitions and numbers relative to population, smaller hospitals and programs that emphasize primary care training should have a financing advantage. Smaller facilities and programs are more likely already focused on resolving shortages of primary care providers. In addition, smaller hospitals and programs are disadvantaged because they do not enjoy the economies of scale in GME financing of large teaching hospitals and academic medical centers, but they do however support the intent of the legislation by ensuring a more decentralized and underserved area-focused training environment.

We strongly support prioritization of funding to rural hospitals that are physically located in rural areas as opposed to urban hospitals that may be designated as serving rural communities. We also support the decision to prioritize primary care geographic HPSAs and the physical location of the hospital in the HPSA. We are concerned that resources are limited to "provider-based facilities" and should rather include "non-provider-based facilities" to ensure that training in Critical Access Hospitals, Rural Health Clinics, Federally Qualified Health Centers (FQHCs), etc. are included in the

financing plan. Consistently, we agree that greater than fifty percent of the training time must occur at facilities within the HPSA.

In terms of resident allocation, typically, a "slot" is defined as a single position funded throughout the length of the training program. For instance, a pediatric resident in a three-year program is considered one FTE resident and not 3 FTE residents. Although we support the growth limitation of 1 FTE per hospital per year, we consider that financing decision to assume the financing of the FTE for the duration of their training and not a separate FTE each year of training in determining the 1,000 new FTE limitation.

Regarding the Five-Year fungibility of slots supported by this proposal, we feel that any reallocation of slots to another program within an organization should also meet the original criteria established in the law, including fifty percent of training time in HPSAs, as well as rural and primary care priorities and not be added to different strategic directions of the hospital, to ensure the public purposes of these GME dollars are met.

We support the proposal that all beneficiary hospitals included in this section attest to meeting the National Standards for Culturally and Linguistically Appropriate Services in Heath and Health Care (National CLAS standards) to move the GME system to more equitable health care provision.

<u>Regarding Section 127 of the Proposed Regulations</u>
We support provisions included in the proposal that:

- Suspend the application of the rolling average in the establishment of new Rural Training Track (RTT) programs;
- Allow for increase in both urban and rural caps from rural training program development;
- Allow the addition of new locations to existing programs to expand the "hub/spoke" model; and,
- Removes the separate accreditation requirement.

We also believe that existing programs that meet the Rural Training definitions, including spending 50% of the training in rural areas, be allowed to add to their current FTE cap via additional language in the proposed regulations for programs expanding on or after October 1, 2022, to ensure consistency with other rural training provisions in this section.

We also understand that there may need to be limitations on the FTE growth, however, since Family Medicine and Psychiatry are the only programs that may receive accreditation from ACGME for greater than fifty percent training outside of the "hub" facility, we feel the regulations should support growth in these program areas consistent with the intent of the legislation. We do not see this as a carte blanche removal of Family Medicine and Psychiatry caps since rural training tracks represent a very small percentage of overall Medicare supported GME activity and this type of training should be incentivized. For instance, the Family Medicine Rural Training Track program between the University of New Mexico and CHRISTUS St. Vincent Regional Medical Center in Santa Fe has been capped at 4 resident per year since 1997 and it is the only residency program in northern New Mexico.

The federal fiscal year is different than the GME academic year by three months. We support aligning the cost reporting periods with training cycles for the purposes of ensuring new rural program are fully funded. Therefore, we recommend a change in the start date for RTT cost-reporting to "on or after July 1, 2022", rather than October 1, 2022.

<u>Regarding Section 131 of the Proposed Regulations</u>

Generally, we are concerned with the offset in timing of the PRA and CAP reset provisions between enactment of the legislation and publishing of these regulations. However, we support the provisions of this section relative to the language regarding eligibility of Category A and B facilities, except those hospitals having a cap that is greater than one but fewer than two seem to be at a training disadvantage. For instance, New Mexico's largest hospital system, has a cap of 1.47 FTE established because of rotations in 1966. We believe there should be a case-by-case review of conditions that impact eligibility in this section for hospitals with a low "incidental" cap, if requested. As in the current environment however, MACs have significant authority in determining Medicare GME payment conditions in facilities that may include cap considerations . We feel that instructions to MACs for determining PRA and CAP conditions should also receive public comment or input. We also offer to work closely with CMS and MACs on an on-going basis to ensure that public GME dollars are aligned in support of access priorities.

Thank you again for the opportunity to provide input on these regulations and we appreciate your efforts to improve health care and access.

Sincerely,



David R. Scrase, M.D.
Secretary
New Mexico Human Services Department

New Mexico Primary Care GME Expansion Board & Advisory Members		
Name	**Medical Training**	**Expertise**
1. David Scrase, M.D.	Geriatrics	Secretary, Department of Human Services
2. Mark Chisholm	-	Academic Affairs and Policy Director, Higher Education Department
3. Oliver Hayes, M.D.	Emergency Medicine	Assoc. Dean of Graduate Medical Education, Burrell College of Osteopathic Medicine
4. John Andazola, M.D.	Family Medicine	Director, Southern New Mexico Family Medicine Residency
5. Alex Cvijanovich, M.D.	Pediatrics	President, NM Pediatrics Society
6. Mauricio Tohen, M.D.	Psychiatry	Chair, Psychiatry & Behavioral Sciences, UNM School of Medicine
7. LaWanda Jim, M.D.	Internal Medicine	Chair, Internal Medicine Department, Northern Navajo Medical Center
8. Alisha Parada, M.D.	Internal Medicine	Medical Director, UNM School of Medicine
9. Darrick Nelson, M.D.	Family Medicine	Residency Program Director, DIO, CMO, Hidalgo Medical Services
10. Eileen Goode, RN	Nursing	CEO, NM Primary Care Association
11. Sarah Friedberg, M.D.	Family Medicine	Graduate, UNM School of Medicine
12. Val Wangler, M.D.	Family Medicine	CMO & Residency Program Director, RMCHCS (Gallup)
13. Jamie Michael	-	Director, Health and Human Services, Doña Ana County

New Mexico Primary Care GME Expansion Board & Advisory Members		
Name	**Medical Training**	**Expertise**
14. Joanna Fair, M.D.	Radiology/Nuclear Medicine	Assoc. Dean of Graduate Medical Education, UNM School of Medicine
15. Mac Bowen, M.D.	Family Medicine	Program Director, NNM Family Medicine Residency Program
16. Jose Canaca, M.D.	Psychiatry	Dept. of Psychiatry, UNM School of Medicine
17. Sabrina Gill, M.D.	Family Medicine	3rd year resident, UNM School of Medicine
18. Pamela Blackwell	-	Director of Policy & Member Services, NM Hospital Assoc.
19. Darra Kingsley, M.D.	Surgery	Associate Chief of Staff for Education, NM VA Health Care
20. Elizabeth Romero, M.D.	Psychiatry	Department of Psychiatry, UNM School of Medicine
21. Neal Bowen, PhD	Psychologist	Director, Behavioral Health Services Division, HSD
22. Anjali Taneja, M.D.	Family Medicine	Executive Director & Medical Director at Casa de Salud

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