HealthAffairsBlog

A State-Based Strategy For Expanding Primary Care Residency

Arthur Kaufman and Charlie Alfero

July 31, 2015

As the health care system looks to improve overall health and reduce unnecessary spending, primary care physicians become increasingly critical. The Affordable Care Act (ACA) recognizes that primary care clinicians have the potential to “bend the cost curve” through care coordination and preventive health care for our increasingly diverse and aging population. However, there aren’t enough primary care physicians to meet this need — especially in rural or poor urban areas. Current estimates predict that by 2035, our country will face a shortage of more than 44,000 primary care physicians.

As in many other states, the people of New Mexico are already experiencing this shortage. In 2014, the state had 96 primary care shortage areas, including areas in 32 of 33 counties in the state. At least 220 new physicians are needed immediately to meet the demand for basic medical care. The state has responded with an innovative and cooperative effort that led to legislation that is already expanding access to care for the state’s neediest residents.

The National Shortage Of Primary Care Residency Slots

While new medical schools are opening and established schools are increasing enrollment across the nation, there’s a residency bottleneck in the physician pipeline in many states, especially in primary care. Most of the funding for the country’s 100,000 residency slots comes from the federal government as part of Medicare spending.

However, the 1997 Balanced Budget Act placed a cap on such graduate medical education spending, effectively freezing it at 1997 levels and often locking in the ratio of primary care to specialty residency positions found at many academic teaching hospitals. Despite the ACA’s recognition of the

importance of primary care, that emphasis has not been reflected in growth in primary care residency positions nationwide.

Within the present payment system, specialty care is more lucrative than primary care, and hospitals may depend on residents, rather than attending physicians, to deliver specialty services in order to recapture financial losses in other areas. Most residencies are based at tertiary care medical centers, which are dominated by subspecialty services and offer fewer opportunities for training in primary care.

The specialty-to-primary care ratio often more closely reflects teaching hospital service needs than of overall health workforce needs. This imbalance is exacerbated by the ability of more lucrative specialty departments to fund residency and fellowship positions outside the Medicare cap. To remedy current primary care shortages and avoid future shortfalls, the country needs to add another 1,700 to 3,000 primary care residency slots.

Although federal legislation has been drafted to better align graduate medical education (GME) with state and national workforce needs, the proposed legislation has not made it through Congress. Nor has there been a sufficient, voluntary movement by academic medical centers to align publicly financed GME with the health goals of the nation.

Solutions are within reach: for example, a 2014 Institute of Medicine report outlines a mechanism for reforming GME payment while expanding public accountability for GME funding. However, policymakers and academic health center leaders have yet to act. Meanwhile the nation is experiencing a well-documented, publicized, and significant worsening of its primary care clinician shortages.

Finding A New Mexico Solution

New Mexico can't afford to wait for Congress to address its primary care shortage. In 2013, a group of physicians, public health advocates, and legislators in the state of New Mexico set out to find a solution.

As part of a consortium of five universities in the Urban Universities for HEALTH program funded by the National Institutes of Health, the University of New Mexico is actively engaged in efforts to recruit more urban and minority students into the health sciences. The program has made important progress: through its changed admissions policies and its rural and minority-oriented BA/MD program, the ethnic composition of the medical school class now reflects the ethnic distribution of New Mexico. However, these steps may not go far enough if graduating physicians cannot obtain the necessary hands-on residency training, especially in primary care within New Mexico's borders.

The New Mexico group looked at data that showed medical residents from minority and rural backgrounds were more likely to remain in New Mexico and to practice in underserved communities. They also considered a study that demonstrated that 70 percent of family medicine residents in New Mexico who trained for two or three years in rural areas of the state continued to practice in rural New Mexico.

These data are backed up by national statistics from The Robert Graham Center that show that 56 percent of residency graduates practice within 100 miles of where they completed training. Based on this analysis, the New Mexico group determined that increasing family medicine training in shortage areas provides the best chance to close the gap between supply and demand for primary care physicians.

Leveraging State Medicaid Funds And Federally Qualified Health Centers

While the federal government is the sole administrator of Medicare, the state-federal partnership inherent in Medicaid programs provides room for innovation. The New Mexico group, inspired by actions taken in Ohio to reallocate Medicaid GME spending to reflect local health workforce priorities,

set out to formulate legislation to address the shortage of primary care residency positions in the state.

The model is made possible through the Community Health Center regulations governing “changes in scope of practice,” which are also allowed by CMS. Traditionally, a change in scope includes new services like oral health or behavioral health. In this case, it adds graduate medical education as an expanded scope of service. The approach is similar to the Health Resources and Services Administration (HRSA)-funded Teaching Community Health Center program. However, federal funding of these Centers in the current political climate can be vulnerable to federal budget cuts.

The budget language, which passed the New Mexico legislature easily in March 2014, redirected state Medicaid funds to help open up new primary residency slots in underserved areas of the state and builds on legislation that established financing for the New Mexico Primary Care Training Consortium in 2013, also through the Medicaid program. The Consortium is comprised of the four family medicine training programs in the state — two programs where the full three years is spent in Albuquerque and Las Cruces, and two “1 + 2” programs where the first year is spent in Albuquerque and the second and third years are spent in either Santa Fe or Silver City.

The New Mexico Human Services Department has agreed to include Federally Qualified Health Center (FQHC)-sponsored primary care residency development in the base Medicaid funding budget and FQHC payment system. Prior to the passage of this legislation, the cost of a specific number of primary care residency slots was a separate line item in the University of New Mexico budget and required further legislative appropriations to increase the number of slots. The new legislation streamlines the process by also allowing the addition of approved primary care training slots at FQHCs through this payment mechanism.

New Mexico is the first state to take this unique approach to funding GME expansion. While there are other states that use Medicaid funds for graduate medical education, only 10 states direct funds specifically toward primary care and none use the same approach as New Mexico. This model represents a critical shift in the paradigm for primary care training. It eliminates the concept of residency caps, other than state budget and program capacity limitations.

For example, if an FQHC wishes to begin or expand a primary care residency and receives approval for this from their Residency Review Committee, that FQHC applies for a change in scope of services to include incremental resident-related costs. If approved, Medicaid issues enhanced payments to the FQHC to cover the incremental costs of the residency program. The estimated cost per resident per year discussed in the initial legislation—approximately $150,000—was based upon the federal grant funding level initially established by HRSA in funding Teaching Community Health Centers in FQHCs. Actual costs may vary.

In addition, while expansion of an existing residency program at an FQHC can be rapid once the expansion is ACGME-approved, it can take several years to create a new program in an FQHC. The state Medicaid program has agreed to pay any FQHC intending to start a new residency or expand an existing one an amount sufficient to cover the reasonable incremental costs associated with the resident month-long rotations on a pro-rated basis, depending upon the number of primary care resident month rotations at the FQHC. This is a natural way to develop resident education capacity.

An Effective, Replicable Solution

Within a year after legislative and administrative approval, the New Mexico Primary Care Training Consortium is already developing 10 primary care residency slots in four locations in some of the more needy parts of New Mexico, including Shiprock and Farmington, both in the heart of Navajo Country, and Las Cruces, on the border between the U.S. and Mexico.

With continuing legislative gridlock in the federal government, innovations in health services and in health workforce development are emerging from states. There, local solutions can grow from local needs and are often more appealing to state legislators who may be wary of federal policy. Although

federal action is needed to address the nation's primary care needs, New Mexico's approach helps to swiftly increase access to care in the state. The model is replicable in other states because it relies on something all states have: state Medicaid dollars and FQHCs.

Author's Note

The following people cooperated to draw up and implement the legislation that created new residency slots in the state of New Mexico:

- *John Andazola, program director, Southern New Mexico Family Medicine Residency, Las Cruces, NM*
- *Darrick Nelson, program director, Hidalgo Medical Services Family Medicine Residency, Silver City, NM*
- *Luis Rigales, program director, Christus St. Vincent's Hospital- La Familia New Mexico Family Medicine Residency, Santa Fe, NM*
- *Dan Waldman, program director, University of New Mexico Family Medicine Residency, Albuquerque, NM*
- *Deborah Weiss, consultant to the New Mexico Primary Care Residency Consortium, Santa Fe, NM*
- *State Senator Howie Morales, New Mexico State Legislature, District 28, Silver City, NM*
- *State Senator Sue Wilson Beffort, New Mexico State Legislature, District 19, Albuquerque, NM*
- *(Former) State Representative Rudolpho "Rudy" Martinez, New Mexico State Legislature, District 39, Las Cruces, NM*
- *Brent Earnest, New Mexico Cabinet Secretary of the Human Services Department, Santa Fe, NM*

ASSOCIATED TOPICS: COSTS AND SPENDING, HEALTH PROFESSIONALS, HOSPITALS, MEDICAID AND CHIP, ORGANIZATION AND DELIVERY, PUBLIC HEALTH, QUALITY
TAGS: ARTHUR KAUFMAN, CHARLIE ALFERO, FEDERALLY QUALIFIED HEALTH CENTER, GME, NEW MEXICO, PRIMARY CARE SHORTAGE