

ANNUAL REPORT SFY 07

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NEW MEXICO HEALTH POLICY COMMISSION

The New Mexico Health Policy Commission

Governor Bill Richardson

Commissioners

Andy R. Lopez, MBA, Chairman

Waldo Anton, Vice-Chairman

Frank Hesse, M.D.

Seferino Montano

Moises Morales

Miles Nelson, M.D.

Alicia Roman

Michael Trujillo, M.D.

Management

Liz Stefanics, PhD., Director

Kristine “Kooch” Jacobus, MA, Deputy Director

Kevin McMullan, MA, Program Manager

Vicky Groskinsky, MA, CISA, CISSP, IT Manager

Peggy Schummers, CFO/HR Manager

Staff

Mary Baca, Financial Specialist

Carlos Beserra, Special Projects Coordinator

Marietta Esquibel, IT Database Administrator

Lisa Marie Gomez, Management Analyst

Reina Guillen, Management Analyst

Tom Kauley, Management Analyst

Elisha Leyba-Tercero, Economist

David Martinez, IT Database Administrator

Irma Montoya, IT Database Administrator

John Murphy, Office & Administrative Support

Howard Nakagawa, Management Analyst

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I. Message from the Director

The NM Health Policy Commission (HPC) is a state agency that was established by statute in 1991 to provide independent research, guidance, and recommendations on health policy issues that impact the planning of health care and health systems for New Mexico.

Our objectives include: contributing to and advancing best practices; collaborating with other state and health care agencies; promoting the agency's role as a researcher and catalyst; and enhancing the HPC's databases to serve as a source of planning for health care and health systems.

The HPC is responsible for providing technical assistance and formulating recommendations for both the Executive and Legislative branches of state government based on an objective analysis of data and information, public and professional input, and quantitative and qualitative research by HPC staff. The Commission is an independent state agency administratively attached to the Department of Finance and Administration of the State of New Mexico.

We invite you to peruse our reports and publications, to participate in our activities, to support us in our mission, and to contact us with your questions.

A handwritten signature in cursive script that reads "Liz Stefanics".

Liz Stefanics, PhD



II. Message from the Chairman

On behalf of the New Mexico Health Policy Commissioners we are pleased to be able to provide the Executive, Legislative, and the state agencies with independent research, bill analysis and recommendations on the multitude of health care issues confronting New Mexico.

The NMHPC has a vast repository of data, multiple reports, and publications that are accessible for use by the general public, researchers, and governmental agencies. The health care policies enable New Mexico to implement the best health care system.

A handwritten signature in black ink that reads "Andy R. Lopez". The signature is written in a cursive style with a long, sweeping tail on the last name.

Andy R. Lopez, MBA

III. Overview

A. Mission Statement

The Health Policy Commission (HPC) is a state agency that provides independent research, guidance and recommendations on health policy issues that impact the health status of New Mexicans.

B. Vision Statement

The Health Policy Commission (HPC) will help New Mexican's improve their health status by being the State's trusted advisor on health policy issues. The Commission will:

- Be valued by peers, colleagues and consumers for it's independence and expertise;
- Provide leadership in identifying and researching critical health and health care delivery issues;
- Provide policy research and recommendations to the legislative and executive branches of state government;
- Maintain a work environment that encourages individual growth and teamwork.

C. Statutory Authority

The HPC is an independent state agency administratively attached to the Department of Finance and Administration. The governing statutes of the health policy commission are:

HEALTH POLICY COMMISSION ACT-Chapter 9-7-11.1, 11.2 NMSA 1978

HEALTH INFORMATION SYSTEMS ACT-Chapter 24-14A-1 NMSA1978

IV. Commission Accomplishments

A. Commissioners

The HPC is composed of nine members appointed by the Governor with the consent of the Legislature to reflect the ethnic, economic, geographic and professional diversity of the state. Members serve staggered three year terms. Current Commission members include:



Andy Lopez, MBA – Chairman

El Rito, NM

Chief Executive Officer of Las Clinicas del Norte Health Center, Board of Directors of the New Mexico Primary Care Association.

Waldo Anton – Vice Chairman

Santa Fe, NM

AARP National Committee Member, Retired State Budget Director, former Deputy Director of Legislative Finance Committee.





Frank Hesse, MD

Albuquerque, NM

Part-time physician with Social Security Administration, retired physician, surgeon and former and Professor at the University of New Mexico.

Seferino Montano

Portales, NM

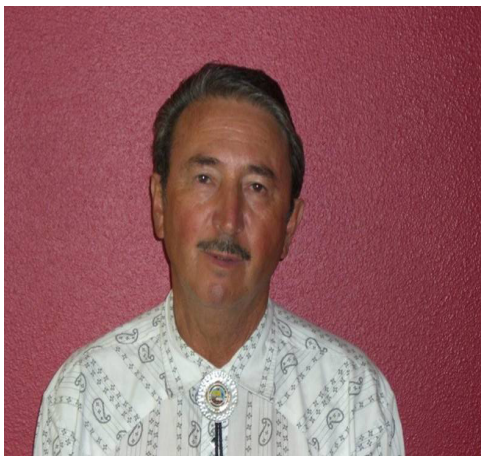
Chief Executive Office of La Casa de Buena Salud, former Primary Care Services Coordinator of Presbyterian Medical Services, former Executive Director of Centro Rural de Salud, Inc.

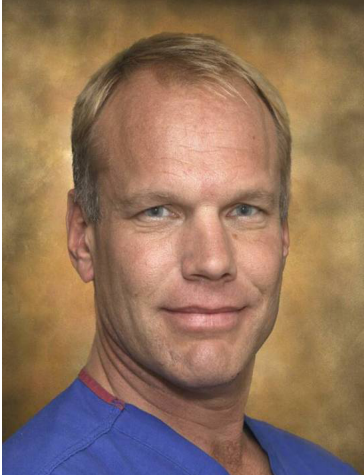


Moises Morales

Tierra Amarilla, NM

Long time health care advocate, full-time rancher.





Miles Nelson, MD

Santa Fe, NM

Emergency Services Physician at St. Vincent Hospital, former Medical Director, Employee Health at Lovelace Medical Center, Member of Board of Directors Northern New Mexico Emergency Medical Services.

Alicia Roman

Sunland Park, NM

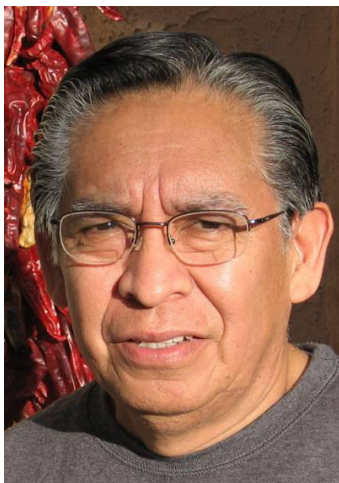
Community health activist, former City Councilor.



Michael Trujillo, MD, MPH, MS

Albuquerque, NM

Executive Director of Translational Genomics Research Institute, former UNM professor and physician of NM Health Science Center, former Indian Health Services National Director



B. Summary of Commission Activities

The Commission conducted meetings in July, September, October, and December of 2006, and in January, February, March, April, and June of 2007 in Albuquerque, Santa Fe, and Taos. Commissioners investigated topics and issues that included the following presentations:

- Behavioral Health Purchasing Collaborative
- UNM/NMSU Cooperative Pharmacy Program
- DOH - Office of School Based Health Services
- Legislative Memorial Update
- Senate and House Health Committee Updates
- HPC Physician Survey
- New Mexico First - Town Hall Meeting
- New Mexico School Administrators, School Based Health Representatives, Public Education Department
- DOH - Office of Behavioral Health
- Diversity and Cultural Competency Groups
- Regulation and Licensure Panel
 - Primary Care Association
 - Counseling and Therapy Board
 - Board of Pharmacy
- University of New Mexico Health Science Center
 - Cancer Center
 - School of Nursing
 - Dental Resident Program
- Oral Health Panel Access Presentation
- Department of Health
 - New Mexico Health Resources
 - Primary Care Association
 - Health and Human Services –Medicaid Office

V. Organization

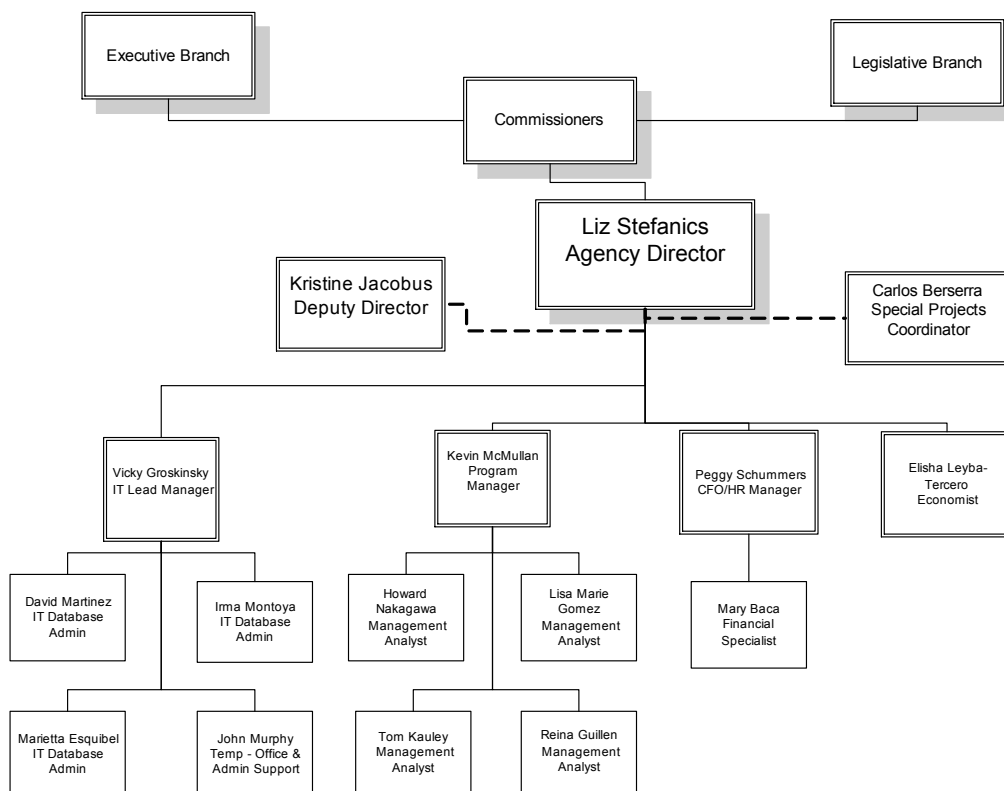
A. Administration

The leadership of the NM Health Policy Commission changed at the end of FY 07 and brought with it some philosophical changes.

The agency had a centralized organization with every staff member reporting directly to the director. The new director believed that a decentralized organization would enhance the agency in completing its mission and established work units – information technology, program, administration, and economic research.

Emphasis was placed on standardizing reports, completing reports in a timely manner, having the reports printed professionally, and branding the reports. Much of this emphasis was completed in the first half of FY 08 and will be continued in the future.

NM Health Policy Commission

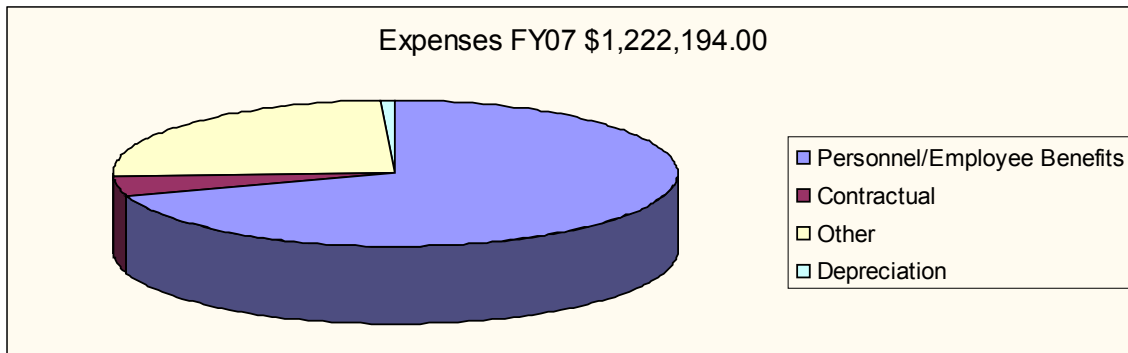
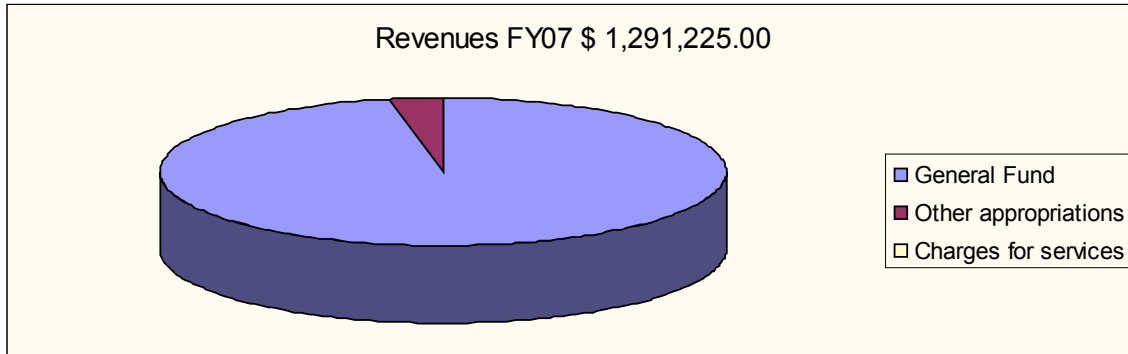


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B. Human Resources

The agency strives to fill all vacancies in a timely manner, but even with the state’s expedited process, it can still require a 2 month period. Many key positions have been reclassified to recruit staff with the knowledge, education, and experience necessary to participate in research endeavors for the Legislative and Executive branches.

C. Finance



Revenues in FY 07 were flat from the previous fiscal year, however expenses increased. Based on appropriated budget, the agency reverted a little over \$130,000, of which \$14,000 was in personnel. Had the agency been fully staffed for the entire fiscal year, the reversion would have been minimal. For FY08, projections show our entire budget will be spent and may even fall short. Based on current spending and projections, the requested budget for FY09 is likely to fall short also.

D. Program

The program staff of the NM Health Policy Commission are required to work on a variety of health policy issues thus requiring staff with health care experience, policy training, and writing skills. Their duties include bill analyses, health trend analyses, memorial topics, financing of health care, research on universal health plans being initiated around the country as examples. Often the research leads to full printed reports that are disseminated to the legislative and executive branches of government, to higher education institutions, and to the public.

The research and writing for memorials usually span parts of two fiscal years. Current topics included nursing recruitment and retention, human papillomavirus prevention, childbirth injury and obstetrical liability insurance, emergency contraceptives, insurance coverage of contraceptives, an uncompensated care definition, and physician supply in New Mexico.

The staff are responsible for the publication of *Quick Facts*, the annual *County Financing of Health Care*, the annual *New Mexico Consumer Guide to Managed Care*, *Hospital Inpatient Discharge Data Reports*, and *Geographic Access Data System Report*. The HPC collaborates with the Department of Health on the *New Mexico Comprehensive Strategic Health Plan*.

The HPC also participated in task force and workgroups. Examples are the Cultural Competence Education in the Health Sciences Task Force, the Regional Health Information Organization Steering Committee, the Telehealth Commission and Alliance, the Interagency Behavioral Health Purchasing Collaborative and Behavioral Health Planning Council, and the Women's Health Advisory Council. Other activities include the J-1 Visa Reviews for Health Professionals and "as needed" information requests from the executive, legislature, organizations, and citizens.

Program staff also participated in the third annual Physician Workforce Research Conference sponsored by the Association of American Medical Colleges, the Annual Health Provider Retreat sponsored by New Mexico Health Resources, and Governor Richardson's Higher Education Summit sponsored by the New Mexico Higher Education Department.

The Commission program staff have an ambitious agenda for 2008 which includes being fully staffed to complete the statutorily required reports and memorials as well as projects that the executive/legislature and the Health Policy Commissioners may request.

Other areas of interest would include the development of a ‘real time’ geographic access database information system similar to what is in place with the Health Professions Tracking Center at the University of Nebraska. This is a maintained relational database that can provide customized reporting of the workforce and can be measured by a variety of parameters. The absence of an effective health care workforce information system hampers efforts to address future shortages and measure the success of initiatives implemented to tackle shortage disparities.

Optimally, the database would be continually maintained to provide a continuum of information from undergraduate education through professional practice, including demographic, training, expertise, languages spoken fluently, retirement plans, practice setting and arrangements for all practice site locations, including satellite offices. The database would be the first step in providing for a health professional workforce development plan in New Mexico.

Further review should be given to collecting data which expands the HIDD (Hospital Inpatient Discharge Database) to include outpatient matrix. Much of the delivery of health care has changed since the HIDD enabling legislation took place in the early 1990s with many services provided on an outpatient basis.

Further research could include the development of a state health expenditure account (SHEA) following up on the work completed by the Legislative Council Service that commenced with HB955 in 2004. This might answer over time how much is being spent on health care (very broadly defined) in New Mexico and what are the components of that spending (e.g. physician, hospital, home care, pharmacy, new building construction, insurance premiums, out-of-pocket spending, etc). The amount spent on health care today in New Mexico is not known. Attempting to enact universal coverage would require a baseline measure of what New Mexicans are spending today as well as anticipated future expenditures.

A current goal of the agency is the participation with thirty seven other states that currently are in the HCUP (Hospital Cost and Utilization) project sponsored by the federal Agency for Healthcare Research and Quality. This is a database which could utilize existing HIDD data to allow comparisons between states on a large number of matrixes associated with hospital services.

E. Information Technology (IT)

The HPC Information Technology (HPC-IT) unit is responsible to collect, store, organize, analyze, and disseminate (manage) the health information data that the HPC uses to provide its health research, guidance, and recommendation services. HPC-IT strives to manage the health data in a way that maintains confidentiality, integrity, and availability.

HPC-IT collects and manages the following health information data to assist entities in making informed health care decisions:

Health Information Data that the HPC May Collect by NM Statute/Rule	Collected in SFY 07
Hospital Inpatient Discharge Data [7 NMAC 1.1.10 B]	Yes
Medicaid data listed by cooperative agreement with NM HSD [7 NMAC 1.1.10 D]	No
Medicare (Part A) data that is mutually agreed upon with fiscal intermediary [7 NMAC 1.1.10 E]	No
Financial Statement of Licensed nonfederal general and specialty inpatient health care facilities [7 NMAC 1.1.10 F]	Partial
Geographic Access System—Data reported by state health professional and facility licensing agencies or boards [7 NMAC 1.23.8 A]	No
Health Plan Data [7 NMAC 1.21]	Yes
Geographic Access System—Data reported by licensed outpatient medical facilities [7 NMAC 1.23.8 B]	No
Geographic Access System—Data reported by state entities administering programs to improve the distribution of health professionals [7 NMAC 1.23.8 C]	Partial
Health Care Surveys—Surveys of licensed health care professionals and/or the administrators of licensed health care facilities [7 NMAC 1.23.13]	Yes
County Indigent Fund [Chapter 27, Article 5 NMSA 1978 may be cited as the “Indigent Hospital and County Health Care Act”]	Yes
Charity Care data—reported from the most recently filed federal Health Care Financing Administration Medicare Cost Report [7 NMAC 1.24]	Partial
Capital Assets Data—reported from the facility’s most recently filed federal Health Care Financing Administration Medicare Cost Report. [7 NMAC 1.25]	No

HPC-IT disseminates the managed health information data listed in the above chart to the Program side of the HPC staff and to external Federal, State, Community and other entities. The information is managed using Microsoft SQL Server 2000 and 2005 with a variety of front-end query tools including SQL query tools and Microsoft Access. The information is disseminated using a variety of platforms including text, Microsoft Word, Microsoft Excel, SAS, PDF, the HPC Web Site, and Arc Serve Mapping.

HPC-IT assists the commission, legislature and other agencies and organizations in the state's efforts in collecting, analyzing and disseminating health information. To this end, HPC-IT collaborates or has plans to collaborate with the following entities in SFY 08:

HPC-IT Collaborative Efforts

- NM Department of Health /Epidemiologists
- NM Department of Health /Vital Records and Health Statistics
- NM Department of Health /Public Health
- NM Telehealth Commission
- NM Telehealth Alliance
- NM CHILI
- Healthcare Cost and Utilization Project (HCUP)
- UNM
- Thompson Healthcare (data clearinghouse)
- New Mexico Hospital Association

HPC-IT is enhancing the following IT processes to accomplish its information management goals for SFY 08:

Plans in progress

- HPC Web Site redesign due in January 08
- Increase access to our managed data
- Revamp HIDD data fields
- Standardize data management and platform—SQL Server
- Better compatibility with other NM health information data
- Better compatibility with other Federal health information data
- Participation in HCUP
- More reliability/ validity cross checks
- Increased collaboration with other health information entities
- Increased collaboration with NM DOIT including collocation of HPC hardware and Web Site and following DOIT policies and procedures

Appendix A

Statutes

9-7-11.2. New Mexico health policy commission created; composition; duties.

- A. There is created the “New Mexico health policy commission”, which is administratively attached to the department of finance and administration.
- B. The New Mexico health policy commission shall consist of nine members appointed by the governor with the advice and consent of the senate to reflect the ethnic, economic, geographic and professional diversity of the state. A majority of the commission members shall have no pecuniary or fiduciary interest in the health services industry while serving or for three years preceding appointment to the commission. Three members shall be appointed for one-year terms, three members shall be appointed for two-year terms, three members shall be appointed for three-year terms and all subsequent appointments shall be made for three-year terms.
- C. The New Mexico health policy commission shall meet at the call of the chair and shall meet not less than quarterly. The chair shall be elected from among the members of the commission. Members of the New Mexico health policy commission shall not be paid but shall receive per diem and mileage expenses as provided in the Per Diem and Mileage Act [10-8-1 NMSA 1978].
- D. The New Mexico health policy commission shall establish task forces as needed to make recommendations to the commission on various health issues. Task force members may include individuals who have expertise or a pecuniary or fiduciary interest in the health services industry. Voting members of a task force may receive mileage expenses if they:
- (1) are members who represent consumer interests;
 - (2) are individuals who were not appointed to represent the views of the organization or agency for which they work; or
 - (3) represent an organization that has a policy of not reimbursing travel expenses of employees or representatives for travel to meetings.
- E. The New Mexico health policy commission shall:
- (1) develop a plan for and monitor the implementation of the state’s health policy;
 - (2) obtain and evaluate information from a broad spectrum of New Mexico’s society to develop and monitor the implementation of the state’s health policy;
 - (3) obtain and evaluate information relating to factors that affect the availability and accessibility of health services and health care personnel in the public and private sectors;
 - (4) perform needs assessments on health personnel, health education and recruitment and retention and make recommendations regarding the training, recruitment, placement and retention of health professionals in underserved areas of the state;
 - (5) prepare and publish an annual report describing the progress in addressing the state’s health policy and planning issues. The report shall include a workplan of goals and objectives for addressing the state’s health policy and planning

issues in the upcoming year;

(6) distribute the annual report to the governor, appropriate state agencies and interim legislative committees and interested parties;

(7) establish a process to prioritize recommendations on program development, resource allocation and proposed legislation;

(8) provide information and analysis on health issues;

(9) serve as a catalyst and synthesizer of health policy in the public and private sectors;

(10) respond to requests by the executive and legislative branches of government; and

(11) ensure that any behavioral health projects, including those relating to mental health and substance abuse, are conducted in compliance with the requirements of Section 9-7-6.4 NMSA 1978.

24-14A-1. Short title.

Chapter 24, Article 14A NMSA 1978 may be cited as the “Health Information System Act”.

24-14A-2. Definitions.

As used in the Health Information System Act [24-14A-1 NMSA 1978]:

- A. “aggregate data” means data which is obtained by combining like data in a manner which precludes specific identification of a single client or provider;
- B. “commission” means the New Mexico health policy commission;
- C. “department” means the department of health;
- D. “health information” or “health data” means any data relating to health care; health status, including environmental, social and economic factors; the health system; or health costs and financing;
- E. “hospital” means any general or special hospital licensed by the department, whether publicly or privately owned;
- F. “long-term care facility” means any skilled nursing facility or nursing facility licensed by the department, whether publicly or privately owned;
- G. “data source” includes those categories of persons or entities that possess health information, including any public or private sector licensed health care practitioner, primary care clinic, ambulatory surgery center, ambulatory urgent care center, ambulatory dialysis unit, home health agency, long-term care facility, hospital, pharmacy, third-party payer and any public entity that has health information; and
- H. “third-party payer” means any public or private payer of health care services and includes health maintenance organizations and health insurers.

24-14A-3. Health information system; creation; duties of commission.

- A. The “health information system” is created for the purpose of assisting the commission, legislature and other agencies and organizations in the state’s efforts in collecting, analyzing and disseminating health information to assist:
 - (1) in the performance of health planning and policymaking functions, including identifying personnel, facility, education and other resource needs and allocating financial, personnel and other resources where appropriate;
 - (2) consumers in making informed decisions regarding health care; and
 - (3) in administering, monitoring and evaluating a statewide health plan.
- B. In carrying out its powers and duties pursuant to the Health Information System Act, the commission shall not duplicate databases that exist in the public sector or databases in the private sector to which it has electronic access. Every governmental entity shall provide the commission with access to its health-related data as needed by the commission. The commission shall collect data from data sources in the most cost-effective and efficient manner.
- C. The commission shall establish, operate and maintain the health information system.
- D. In establishing, operating and maintaining the health information system, the

commission shall:

- (1) obtain information on the following health factors:
 - (a) mortality and natality, including accidental causes of death;
 - (b) morbidity;
 - (c) health behavior;
 - (d) disability;
 - (e) health system costs, availability, utilization and revenues;
 - (f) environmental factors;
 - (g) health personnel;
 - (h) demographic factors;
 - (i) social, cultural and economic conditions affecting health, including language preference;
 - (j) family status;
 - (k) medical and practice outcomes as measured by nationally accepted standards and quality of care; and
 - (l) participation in clinical research trials;
- (2) give the highest priority in data gathering to information needed to implement and monitor progress toward achievement of the state health policy, including determining where additional health resources such as personnel, programs and facilities are most needed, what those additional resources should be and how existing resources should be reallocated;
- (3) standardize collection and specific methods of measurement across databases and use scientific sampling or complete enumeration for collecting and reporting health information;
- (4) take adequate measures to provide health information system security for all health data acquired under the Health Information System Act and protect individual patient and provider confidentiality. The right to privacy for the individual shall be a major consideration in the collection and analysis of health data and shall be protected in the reporting of results;
- (5) adopt and promulgate rules necessary to establish and administer the provisions of the Health Information System Act, including an appeals process for data sources and procedures to protect data source proprietary information from public disclosure;
- (6) establish definitions, formats and other common information standards for core health data elements of the health information system in order to provide an integrated financial, statistical and clinical health information system, including a geographic information system, that allows data sharing and linking across databases maintained by data sources and federal, state and local public agencies;
- (7) develop and maintain health and health-related data inventories and technical documentation on data holdings in the public and private sectors;
- (8) collect, analyze and make available health data to support preventive health care practices and to facilitate the establishment of appropriate benchmark data to measure performance improvements over time;
- (9) establish and maintain a systematic approach to the collection and storage of health data for longitudinal, demographic and policy impact studies;
- (10) use expert system-based protocols to identify individual and population

health risk profiles and to assist in the delivery of primary and preventive health care services;

(11) collect health data sufficient for consumers to be able to evaluate health care services, plans, providers and payers and to make informed decisions regarding quality, cost and outcome of care across the spectrum of health care services, providers and payers;

(12) collect comprehensive information on major capital expenditures for facilities, equipment by type and by data source and significant facility capacity reductions; provided that for the purposes of this paragraph and Section 24-14A-5 NMSA 1978, "major capital expenditure" means purchases of at least one million dollars (\$1,000,000) for construction or renovation of facilities and at least five hundred thousand dollars (\$500,000) for purchase or lease of equipment, and "significant facility capacity reductions" means those reductions in facility capacities as defined by the advisory committee established by the commission;

(13) serve as a health information clearinghouse, including facilitating private and public collaborative, coordinated data collection and sharing and access to appropriate data and information, maintaining patient and client confidentiality in accordance with state and federal requirements;

(14) collect data in the most cost-efficient and effective method feasible and adopt regulations, after receiving recommendations from the advisory committee, that place a limit on the maximum amount of unreimbursed costs that a data source can incur in any year for the purposes of complying with the data requirements of the Health Information System Act; and

(15) identify disparities in health care access and quality by aggregating the information collected pursuant to Paragraph (1) of Subsection D of this section by population subgroups to include race, ethnicity, gender and age.

24-14A-4. Health information system; applicability.

- A. All data sources shall participate in the health information system. Requests for health data under the Health Information System Act [24-14A-1 NMSA 1978] from a member of a data source category shall, where reasonable and equitable, be made to all members of that data source category.
- B. Upon making any request for health data pursuant to the Health Information System Act, the commission shall provide reasonable deadlines for compliance and shall give notice that noncompliance may subject the person to a civil penalty pursuant to Section 24-14A-10 NMSA 1978.
- C. To the extent possible, the health information system shall be established in a manner to facilitate the exchange of information with other databases, including those maintained by the Indian health service and various agencies of the federal government.

24-14A-4.1. Annual review of data needs.

At least once each year, the commission shall review its data collection requirements to determine the relevancy of the data elements on which it collects data and review its

regulations and procedures for collecting, analyzing and reporting data for efficiency, effectiveness and appropriateness. The review shall consider the cost incurred by data sources to collect and submit data.

24-14A-4.2. Investigatory powers.

The commission has the right to verify the accuracy of data provided by any data source. The verification may include requiring the data source to submit documentation sufficient to verify the accuracy of the data in question or to provide direct inspection during normal business hours of only the records and documents that pertain directly to the data in question; provided that no data source shall be required to expend more than twenty-five thousand dollars (\$25,000) each year to comply with the provisions of this section.

24-14A-4.3. Agency cooperation.

All state agencies and political subdivisions shall cooperate with and assist the commission in carrying out the provisions of the Health Information System Act [24-14A-1 NMSA 1978], including sharing information and joining in any appropriate health information system.

24-14A-5. Health information system; implementation; regulations.

In order to minimize the imposition of new reporting requirements on persons subject to the provisions of the Health Information System Act [24-14A-1 NMSA 1978], the regulations to the extent reasonably possible shall provide that:

- A. data shall be collected in a uniform manner;
- B. when practicable, data collection shall be through the use of a standardized billing form as required by law;
- C. other health data required to be submitted may include:
 - (1) data that would customarily be collected in the ordinary course of business for the data source;
 - (2) annual audited financial statements customarily prepared by a data source;
 - (3) information on major capital expenditures;
 - (4) data established by regulation to be collected to carry out the requirements of the Health Information System Act; and
 - (5) data required to be collected by other state or federal laws; and
- D. annual surveys or collection of data may be used as an alternative to collection of health data from some health service providers to the extent it can be shown that the information collected will meet validity and quality standards.

24-14A-6. Health information system; access.

- A. Access to data in the health information system shall be provided in accordance with regulations adopted by the commission pursuant to the Health Information System Act [24-14A-1 NMSA 1978].
- B. A data provider may obtain data it has submitted to the system, as well as aggregate data, but it may not access data submitted by another provider which is limited only to that provider. In no event may a data provider obtain data regarding an individual patient except in instances where that data was originally submitted by the requesting provider. Prior to the release of any data, in any form, data sources shall be permitted the opportunity to verify the accuracy of the data pertaining to that data source. Any data identified in writing as inaccurate shall be corrected prior to the data's release. Time limits shall be set for the submission and review of data by data sources and penalties shall be established for failure to submit and review the data within the established time.
- C. Any person may obtain any aggregate data.

24-14A-7. Health information system; reports.

- A. A report in printed format that provides information of use to the general public shall be produced annually. The report shall be made available upon request. The commission may make the report available on tape or other electronic format.
- B. The commission shall provide an annual report of its activities, including health care system statistics, to the legislature. The report shall be submitted by November 15 each year.

24-14A-8. Health information system; confidentiality.

- A. Health information collected and disseminated pursuant to the Health Information System Act [24-14A-1 NMSA 1978] is strictly confidential and shall not be a matter of public record or accessible to the public except as provided in Sections 24-14A-6 and 24-14A-7 NMSA 1978. No data source shall be liable for damages to any person for having furnished the information.
- B. The individual forms, computer tapes or other forms of data collected by and furnished for the health information system shall not be public records subject to inspection pursuant to Section 14-2-1 NMSA 1978. Compilations of aggregate data prepared for release or dissemination from the data collected, except for a report prepared for an individual data provider containing information concerning only its transactions, shall be public records.

24-14A-9. Health information system; fees.

Except for the annual reports required pursuant to the Health Information System Act [24-14A-1 NMSA 1978], the commission may collect a fee of up to one hundred dollars (\$100) per hour to offset partially the costs of producing public-use data aggregations

or data for single use special studies. Entities contributing data to the system shall be charged reduced rates. Rates shall be established by regulation and shall be reviewed annually. Fees collected pursuant to this section are appropriated to the commission to carry out the provisions of the Health Information System Act.

24-14A-10. Health information system; violation; civil penalty.

- A. It is unlawful for any person subject to the data reporting requirements of the Health Information System Act [24-14A-1 NMSA 1978] and the regulations adopted pursuant to that act not to comply with any of those requirements.
- B. A civil action may be brought in the name of the state alleging a violation of Subsection A of this section and a petition may be made to the district court for temporary or permanent injunctive relief. In any such action, if the court finds that a person has wilfully violated Subsection A of this section, upon petition to the court there may be recovered on behalf of the state a civil penalty not to exceed one thousand dollars (\$1,000).

Appendix B
Executive Summaries - Memorials

HM 10 Contraceptive Use and Insurance Coverage

In 2001, two sections of law were enacted, Sections 59A-22-42 and 59A-46-44 NMSA 1978, which require health insurers and health maintenance organizations that provide a prescription drug benefit to also provide coverage for prescription contraceptive drugs or devices.

Subsequent to the effective date of the laws, complaints were received concerning failure to provide this coverage. Investigations determined that some insurers were not aware of the change in law and were in violation of the law. As a result, in 2002, House Joint Memorial 32 (HJM 32) requested that the Superintendent of Insurance conduct a survey of health insurers to determine 1) compliance with the law and 2) the number of religious entities opting out. The study found that fewer than 10% of health insurers offered prescription contraceptive coverage.

The 2006 House Memorial 38 (HM 38) was directly related to the 2002 HJM 32. HM 38 requested that the New Mexico Health Policy Commission (HPC), in coordination with the Insurance Division (DOI) of the Public Regulation Commission (PRC), evaluate the benefits of contraception use, disseminate insurance coverage information to the public, and update the study of the insurance industry's compliance with requirements to offer coverage for prescription contraceptives.

During the 2007 Legislative session, the New Mexico House of Representatives enacted House Memorial 10 (HM 10), which is another memorial related to this issue. HM 10 requested that the HPC work with DOI to continue to gather and assess information regarding the compliance of the insurance industry with New Mexico laws requiring prescription contraception coverage. In addition, HM 10 requested that the agencies disseminate the information gathered by means of the *New Mexico Contraceptive Coverage* web site, among other methods of public outreach, and provide an evaluation of the compliance of health insurers in the state. Further, HM 10 requested that the HPC and DOI expand and update the *New Mexico Contraceptive Coverage* web site to raise the level of public awareness of insurance coverage of contraceptives.

Pursuant to the requests set forth in HM 10, this report serves as a continuation and update of the 2006 HM 38 report, with a primary focus on the insurance industry's compliance with New Mexico law requiring prescription contraception coverage. This report includes new or updated information on the following topics:

- Approval of Lybrel – In May of 2007, the U.S. Food and Drug Administration (FDA) approved Lybrel, the first continuous drug product for prevention of pregnancy. It is important to note that although Lybrel was not part of the previous memorial, it is related to the study as it is a new contraceptive product available for use by women.
- Uninsured Women - nearly 35 million women depend on contraceptive care; however, many women are uninsured and cannot afford to pay for this type of

care on their own. Data show that 24% of New Mexico Women are uninsured.

- National Contraceptive Coverage Data - In 2006, 25 states had required insurers that cover prescription drugs to provide coverage of the full range of FDA-approved contraceptive drugs and devices. Today 26 states require this type of coverage.
- Survey of New Mexico Health Insurers – In 2006, DOI surveyed 359 New Mexico health insurers to determine whether or not they were in compliance with the New Mexico law requiring prescription contraceptive coverage. DOI received a total of 287 responses and included the results from those responses in the 2006 HM 38 report. Subsequent to the completion of the report, DOI received 2 additional responses. In 2007, pursuant to HM 10, DOI sent letters and conducted follow-up calls to the remaining 70 health insurers who had not submitted a response to the 2006 survey. Consequently, DOI received responses from all 70 insurers, completing the 2006 survey.
- *New Mexico Contraceptive Coverage* web site – In 2006, the HPC created the *New Mexico Contraceptive Coverage* web site as a result of HM 38. The web site includes information on New Mexico contraceptive coverage laws, FDA-approved contraceptives, a list of insurers that provide coverage and links to their sites, and information on how consumers may file a complaint if an insurer is required to provide coverage and is not. Pursuant to HM 10, the HPC has updated its web site to include a complete listing of New Mexico insurers providing contraceptive coverage, in addition to those not providing coverage, based on DOI's updated survey results. In addition, the HPC is expanding its web site to include information on Plan B, the only dedicated emergency contraceptive drug, including a listing of pharmacies and clinics in New Mexico that do and do not dispense Plan B and have permitted the HPC to publish their names on a public list. This information is available as a result of the 2007 House Memorial 11 (HM 11), a study on the availability and accessibility of emergency contraception in New Mexico. For more information on the HM 11 study, please visit www.hpc.state.nm.us.

HM 11 Emergency Contraception in NM

During the 2007 Legislative session, the New Mexico House of Representatives enacted House Memorial 11 (HM 11), requesting that the Health Policy Commission (HPC), in coordination with the Department of Health, the Board of Pharmacy and other organizations, study the availability of emergency contraception (EC) throughout New Mexico. HM 11 requested that the HPC conduct a study to determine the availability and accessibility of Plan B, including a survey of state pharmacies regarding their policies surrounding the stocking and dispensing of Plan B. HM 11 further requested that the HPC compile and evaluate the results of the survey and prepare a report on the availability of EC in New Mexico, including Plan B, to the appropriate legislative committee by November 2007.

HM 11 requested that the HPC create and coordinate a working group (HM 11 Working Group) that included representatives from the Department of Health, New Mexico Pharmacists Association, the Board of Pharmacy and community representatives with expertise and knowledge about the availability and accessibility of EC in the state. Other interested groups including representatives from the University of New Mexico and those listed as HM 11 Working Group members were invited to participate to allow for broad input and expertise. The HM 11 Working Group held monthly meetings to gather and discuss information regarding the issues surrounding availability of and access to EC and Plan B in particular, including the over-the-counter availability of and access to Plan B.

A survey was developed by the group and sent to licensed clinics and pharmacies in New Mexico, including IHS clinics. The survey results suggest a variety of stocking and dispensing policies in pharmacies throughout the state. Several clinics and pharmacies did not know whether their facilities had certain policies. Over 11% of clinics and over 16% of pharmacies did not know whether their facility had a policy regarding the stocking or dispensing of Plan B, including the over-the-counter dispensing of Plan B, as approved by the Food and Drug Administration. Over 17% of clinics and nearly 22% of pharmacies indicated that they did not know whether their facility had a policy for allowing individual pharmacists to refuse to dispense ECs, including Plan B, solely for religious or moral reasons.

Most clinics and pharmacies indicated that they dispensed Plan B with a prescription. However, 48 (43.24%) clinics and 24 (13.64%) pharmacies did not dispense Plan B with a prescription. Of the clinic and pharmacy respondents that dispensed Plan B with a prescription, 20 (25.32%) clinics and 130 (82.80%) pharmacies indicated that they also dispensed Plan B over-the-counter. Seventy-six respondents (32.20%), 51 (64.56%) clinics and 25 (15.92%) pharmacies did not dispense Plan B over-the-counter. Most pharmacies dispensing Plan B with a prescription but not over-the-counter indicated that the reason for not dispensing over-the-counter was a lack of patient demand.

The HM 11 Working Group agreed that pharmacy stocking and dispensing policies as well as mechanisms for ensuring that rural, poor, low-income and uninsured New Mexicans are able to receive Plan B promptly are critical issues when addressing the

availability and accessibility of EC in the state.

The group developed recommendations for the Legislature to consider that could increase access to EC throughout New Mexico. Because Plan B is currently the only dedicated EC pill available on the market, the recommendations refer to Plan B, but are meant to include any other comparable, effective EC pill that may become available in the future. The following is a list of the HM 11 Working Group recommendations, all of which were consensus recommendations:

1. **Support state funding for increased community education** regarding Plan B through the efforts of the Governor's Women's Health Advisory Council.
2. **Support state funding for increased provider education** regarding Plan B, including pharmacists and other pharmacy staff, healthcare providers and public health officials.
3. **Create an incentive program to encourage pharmacists to participate in EC clinical services** including EC prescribing.
4. **Support increased state funding to the state Medicaid program and healthcare clinics that serve women of child-bearing age** to ensure access and provide EC to low-income women throughout New Mexico.
5. **Create a public resource**, through the efforts of the Governor's Women's Health Advisory Council, to provide healthcare providers, patients and pharmacists information on which pharmacies and clinics in the state stock and dispense Plan B.
6. **Develop clear policies regarding "pharmacy refusal"** to ensure that personal religious and moral objections not based on professional judgment do not deprive patients of timely access to EC.
7. **Ensure that pharmacies follow the least onerous ID policies** permitted by the FDA to determine whether a patient is an adult who does not need a prescription to obtain Plan B.
8. **Ensure that all emergency rooms comply with the state statute** mandating that rape victims be offered EC.
9. **Support new and ongoing research** of the following:
 - A. **Patient use of and access to EC** in NM, particularly among vulnerable populations.
 - B. Whether patients who seek EC are also obtaining **regular birth control alternatives**.
 - C. **Evaluation and implementation of pharmacist incentives** for EC clinical services.
10. **Support community and provider education** to ensure that minors are able to obtain prescriptions for EC and that minors with a valid prescription are able to obtain EC.

HM17/SM18 Nurse Recruitment and Retention

The Forty-Eighth session of the New Mexico Legislature adopted House Memorial 17 (HM17) and Senate Memorial 18 (SM18). Both the House and Senate memorials are identical. For purpose of this report and for conciseness, HM17 will be noted throughout and SM18 will not. The memorials requested that the New Mexico Health Policy Commission (HPC) study the impact of nurse recruitment and retention issues and recommend ways in which nurse turnover and vacancy rates can be addressed.

House Memorial 17 requested that the HPC create and coordinate a working group that included representatives from the board of nursing, statewide associations representing hospitals and health systems, physicians, nurses, nurse executives, labor organizations representing nursing and a statewide organization dedicated to excellence in nursing. The work group, comprised of a diverse group of stakeholders knowledgeable about nursing and medical care delivery in New Mexico, conducted a series of meetings to identify the specific information and recommendations contained in this report. Additionally, the work group designated three sub-committees to identify research and information focused on three topic areas – 1) Quantify the Needs (Nurse Workforce); 2) Nursing Education; and 3) Nursing Environment.

The report on the 2005 House Joint Memorial 37, *A Study on Impact of Nurse Staffing and Retention Issues on Workforce Development*, stated that New Mexico is in the midst of a nursing shortage that will worsen by the year 2020. Data on nurse retention and vacancy, especially by nurse specialty (i.e. critical care nurse, neonatal nurse, emergency nurse, etc.) is not gathered in New Mexico. There is a need to collect, synthesize, analyze and report data on our nursing workforce in New Mexico so that policy makers and educators address this problem in a rational and fiscally sound manner.

Specific to New Mexico, the higher education system does not meet the demands for new nurses in the workforce or for slots in student nursing programs. In some college training programs, there is currently a three year waiting period for acceptance into the programs. Members of the task force indicate that the current nursing shortage in New Mexico is acute and will worsen.

The scientific literature on nurse retention and turnover suggests the positive aspects of nursing, such as coordinating care and promoting health, are associated with strong job satisfaction. In contrast, the factors resulting in nurse dissatisfaction and turnover have to do primarily with the frustrations of getting the job done in an environment of limited resources. Nurses feel overburdened by non-nursing activities which leads to job dissatisfaction and ultimately to increased turnover. Additionally, since the nursing workforce is aging, consideration must be given to the unique requirements of this aging workforce.

The HM17 work group made recommendations in three general areas to address the nursing shortage. The general areas and specific recommendation are listed below:

Workforce Data

Requests the 2009 Legislature direct the Department of Health and Health Policy Commission to convene a task force to develop a plan for health workforce data to encompass all health professions in all healthcare settings.

Nursing Education

Recommends the 2009 Legislature increase the amount of funding to the Higher Education Department for nursing education expansion. The funds will be used by the Higher Education Department (HED) institutions for the following areas:

1. faculty salaries,
2. clinical sites/experiences,
3. emphasis on collaboration between institutions, and
4. increasing public –private partnerships.

Recommends the HED convene a work group of nurse educators, employers, board of nursing, nurses and nursing organizations to study and recommend what is needed in the recruitment, education and transition from nursing into new nursing faculty at higher education institutions.

Recommends the 2009 Legislature task the Health Policy Commission to study and make recommendations regarding nursing faculty salaries.

Nursing Work Environment

Strongly encourages New Mexico's hospitals to pursue Magnet or Nurse Friendly Accreditation.

Recommends the 2009 Legislature fund a one-time \$15,000 grant to a qualified organization for consultative fees associated with establishing a Magnet or Nurse Friendly accreditation model.

Recommends the 2009 Legislature names and directs a work group to explore incentives for hospitals and other healthcare facilities to achieve Magnet or Nurse Friendly accreditation.

Recommends the 2009 Legislature mandate a "Nursing Acuity Committee." The committee will establish guidelines for hospital nurse – patient acuity practices. This legislation can be modeled after Illinois law (SB867).

Encourages each hospital in New Mexico to form a "Nurse Satisfaction and Retention Committee" to be made up of at least 50% working staff.

SM 34 Study & Define Uncompensated Charity Care

During the 2007 session of the New Mexico legislature, Senate Memorial 34 (SM 34) was passed. The memorial requested that the Health Policy Commission (HPC) convene a task force comprised of nine members appointed by the legislative leadership. The task force was to include diverse representation from large, small, rural, and urban hospitals throughout the state; federally qualified health centers; community-based primary care clinics; community leaders; and indigent fund representatives of county commissions who set policy for indigent or uncompensated care. In addition, the memorial requested that a member of the house of representatives and a member of the senate from the 2006 interim legislative health and human services committee be appointed by the chair and vice chair of that committee to serve as advisors to the task force. The memorial further requested that the task force and advisors present conclusions, including a working definition of “uncompensated care”, at the November 2007 meeting of the legislative health and human services committee.

The SM 34 task force met in October 2007 to define and develop a calculation for “uncompensated care”. After much discussion, the task force determined that in order to define “uncompensated care”, other terms also needed to be defined. These terms included operating costs, gross patient charges, bad debt, charity care, and cost-to-charge ratio. Taking into consideration the Generally Accepted Accounting Principles (GAAP) guidelines, which all entities must utilize for financial statements, the task force defined these terms as follows:

Operating Costs - The expenses required to deliver health care including interest, depreciation, amortization and overhead. The operating cost of a health care provider varies by entity and is exclusive of bad debt.

Gross Patient Charges - The non-discounted amounts required to be charged to all patients for care. Charges will vary from entity to entity.

Bad Debt - Accounts that are written off on a gross charge basis for services for which payment was anticipated, but not received. The policy of each entity will determine when an account may be written off. Similar to charity care, bad debt amounts are charges that must be converted to cost for the purpose of determining amounts of uncompensated care.

Charity Care - Sometimes referred to as “indigent care” (not to be confused with “indigent fund”), is health care service provided to patients who are not able to pay for such service. Gross charges for services must be converted to cost for the purpose of determining and reporting the amount of charity care.

Cost-to-Charge Ratio - The ratio of costs to gross charges from audited financial statements. It is total operating costs (exclusive of bad debt at cost) divided by gross patient charges.

Cost-to-Charge Ratio = total operating costs ÷ gross patient charges

These terms are included in the task force's definition and calculation of "uncompensated care":

Uncompensated Care – a health care provider's bad debt and charity care.

Uncompensated care is calculated as follows:

$$\text{Uncompensated Care} = (\text{Bad debt} + \text{charity care}) \times \text{cost-to-charge ratio}$$

NOTE: UNCOMPENSATED CARE IS CALCULATED ON AN ENTITY BY ENTITY BASIS.

The SM 34 task force also discussed issues associated with "indigent care". The task force agreed that it is important to note that "indigent care" is different from that of county "indigent funds". Policies set by counties with respect to their indigent funds may not reflect policies set by health care providers with respect to indigent care.

HJM39 HPV Advisory Panel

During the 2007 Legislative session, the New Mexico House of Representatives enacted House Joint Memorial 39. HJM 39 requested a formal collaboration of the Health Policy Commission (HPC) with the Human Papillomavirus-Papanicolaou Advisory Panel to create a research agenda to study and identify cervical cancer disparities and cost-effective delivery of primary and secondary cervical cancer interventions that will protect and improve the health of New Mexico women.

The New Mexico Health Policy Commission and the New Mexico Department of Health formed an HPV advisory panel. Experts in cervical cancer, precancers and the Human Papillomavirus (HPV) were part of the panel as were members of the community, public schools and state agencies who provide screening, immunization, and education.

The Panel focused on the HPV virus (Types 16 and 18) that causes cervical cancer. HJM 39 (2007) stated that almost 400 women are diagnosed with cervical cancer each year. Another 26 die. Two-thirds of women newly diagnosed with invasive cervical cancer are under the age of 55. However, two of every three cervical cancer deaths occur among women age 55 and older. This is thought to be likely because of lack of cervical cancer screening earlier in life.

Recommendations

The HPV advisory panel recommends interventions to the existing system.

1. Request all New Mexico medical providers be able to access and retrieve accurate and current HPV vaccination data in their offices via the State Immunization Information System (SIIS) on a real time basis.

State funding of two NM DOH /SIIS specific quality control and assurance programmers could support this effort.

- The staff would develop and create interface with all new and existing medical providers' numerous computer systems to SIIS.
- The staff would train providers, their office personnel, school health personnel and others in utilization of SIIS.
- The staff would be responsible for ongoing maintenance of DOH SIIS.

2. Increase the number of cervical cancer screenings and access to treatment.

- State funding of BCC cervical cancer screenings could support this effort.
- The New Mexico Legislature could consider funding and expanding the eligibility criteria for the Medicaid 052 program as other states have done.

3. Request New Mexico Department of Health to evaluate the cost and medical effectiveness of implementing newer technologies such as the "thin prep" and self-sampling technique.

4. Request the Governor's Women's Health Advisory Council to create an innovative and highly visible media/educational campaign to decrease the number of New Mexico citizens with HPV, precancers or cervical cancer.

- This effort could involve adding cervical cancer screening and tracking of HPV immunization as a performance standard on private and public insurance programs.
- This effort could highlight that HPV occurs in men and that HPV can be transmitted back and forth between sexual partners.
- State funding to create educational materials that are factual, culturally appropriate, and include information about the need to get Pap tests, with the advisory panel helping coordinate these educational efforts, could support this effort.

5. Reauthorize the HPV advisory panel as a group of experts in HPV, precancers and cervical cancer prevention and interventions and to report to the Legislature. The panel's role and responsibilities would be to:

- Investigate research opportunities to benefit New Mexicans.
- Measure effectiveness of recommendations.
- Work with HPV and cervical cancer issues to identify interventions for males and females.

Childbirth Injury and Obstetrical Liability Insurance

The New Mexico Health Policy Commission (HPC) was appropriated \$30,000 during the 2006 Legislative Session and \$20,000 during the 2007 session in order to “examine alternatives for resolving problems related to reducing the injuries suffered in the course of childbirth and the cost and availability of malpractice insurance for childbirth health care professionals and institutions.” The HPC assembled a task force including an obstetrician from the University of New Mexico (UNM) School of Medicine and president of New Mexico American College of Obstetrics and Gynecology, certified nurse midwives from the UNM School of Nursing, a community-based licensed midwife, an attorney from the UNM Law School’s Institute of Public Law and staff from the Insurance Division of the Public Regulation Commission.

The cost of malpractice insurance for medical providers continues to escalate in New Mexico and across the nation. The cost escalation threatens access to childbirth services for some New Mexico residents as costs of insurance threaten the financial viability of obstetrical providers, especially nurse midwives. The information collected by the task force indicated that this is an issue throughout the entire state, but has especially impacted rural obstetrical providers leaving fewer care options available to many New Mexicans.

This task force, which has been active since June 2006, has conducted written surveys; talked with New Mexico providers, reviewed prior analyses, studies, and literature, and consulted with experts in the fields of patient safety, professional liability insurance, and compensation reform. The workforce delivering babies outside of the governmental and corporate healthcare umbrella is thinly spread and strained to maintain services by continued increases in costs of malpractice insurance, particularly among certified nurse midwives. The task force’s next step is to build dialog to establish the extent to which this same set of problems is impacting large governmental and corporate organizations and if a common set of administrative solutions across sectors of the market can be developed.

Below are the task force recommendations:

Task force Recommendations-

- 1) Establish a reinsurance program similar to that of Oregon for subsidizing medical professional liability costs to obstetricians, family physicians, nurse-midwives and licensed midwives who do births and provide substantial publicly funded and uncompensated care in their practices.** The goal of such legislation would be to maintain and improve statewide access to obstetrical health care by reducing the out of pocket medical malpractice premium costs thereby stabilizing, and ideally increasing, the numbers of such obstetrical medical professionals throughout New Mexico.
- 2) Develop an administrative compensation system for patients incurring an injury in the course of childbirth.**

- 3) **Create or aid the establishment of a New Mexico Patient Safety Organization**, pursuant to the federal Patient Safety and Quality Improvement Act of 2005, upon finalization of federal rules for the Patient Safety Organization Program.

Appendix C

Executive Summaries - HPC Reports

County Financing of Health Care 2007

New Mexico counties that collect and expend taxes for indigent health care are statutorily required to report annually their financial and service data. To facilitate the data collection process, the Health Policy Commission (HPC) has standardized data reporting by providing participating counties with an annual County Funded Health Care Survey. From the returned survey, the HPC compiles, analyzes, and prepares the County Financing of Health Care report.

Thirty of New Mexico's 33 counties currently provide reimbursement for indigent health care services, through County Indigent Funds and other sources to their residents. Catron, Harding and Socorro do not formally participate in the County Indigent Fund program.

All 30 participating counties responded to the HPC's 2007 survey with information regarding funds used for indigent health care and health care capital expenditures. The County Funding of Health Care Survey was revised in 2007. The HPC developed the revised survey based on the recommendations of the County Representatives Redesign Task Force. Representatives from Curry, Doña Ana, Lincoln, and Santa Fe Counties participated on this task force. These representatives met in collaboration with HPC staff in a series of working meetings to produce the final 2007 County Financing of Health Care Survey.

The 2007 CFHC survey reports that:

- The average beginning balance for the 29 reporting counties was about \$486,700;
- Beginning balances ranged from a negative \$12,206 for Torrance County to \$4,659,319 for Santa Fe County;
- NM counties collected \$75.6 million for county indigent funds primarily through gross receipt taxes;
- NM counties provided \$82.4 million for indigent medical services, with \$14.2 million provided to county supported Medicaid, \$44.7 million for Sole Community Provider Fund (SCPF) hospitals, \$20.4 million provided to medical providers and contractors, \$1.7 million for administrative costs, and \$1.2 million was used for other expenses;
- NM Counties reported that County Indigent Fund expenditures exceeded revenues by 9.1% in 2007;
- The average ending balance for the reporting counties was about \$258,500;
- Twelve counties ended the year with balances less than \$100,000;

- Santa Fe County's ending balance of \$5,040,943 was the highest ending balance of the reporting County Indigent Fund counties; and,
- DeBaca County reported that no indigent claims were paid during State Fiscal Year (SFY) 07.

Some counties also collected health care funds from other county sources, including, but not limited to, the sale of property, mill levy taxes, investment income and grants. Both revenues and expenditures from these other county funds increased during SFY07.

The goal of the task force and the HPC was to simplify the survey while producing information that is useful to counties and legislators. To this end, numerous sections and questions from the previous survey format were determined to be duplicative or unnecessary and were subsequently deleted.

The 2006 NM Geographical Access Data System & Selected Health Professionals in NM

The Health Policy Commission (HPC) collects information from various licensing boards and maintains a Geographic Access Data System (GADS) pursuant to Section 24-14A-1, NMSA 1978. Under the act, all state health professional and facility licensing authorities of the State of New Mexico are required to supply to the HPC every quarter, licensure information including demographic, professional education and specialty training data.

Licensure data may not contain all information necessary to effectively analyze New Mexico's health care workforce. For example, licensure data does not contain how many hours a health care professional is actually employed. Further, the holding of an active license does not necessarily indicate that a health professional is engaged in active practice in the state or what the scope of active practice may be. While licensure data may not accurately depict the number of actively practicing health professionals in New Mexico, its value is longitudinal in nature, and it can consistently measure aspects of the health professional population over time.

This report is intended to provide a snapshot of New Mexico's health care workforce. In this report, we have focused on four types of health professionals: dentists, nurses, pharmacists and physicians. In 2006, New Mexico had a total of 882 active, licensed dentists; 1,486 active, licensed pharmacists; and 6,565 active, licensed physicians. The number of licensed registered nurses (RNs) increased by 3.44% from 15,164 in fiscal Year 2006 (FY06) to 15,686 in FY07.

Not all New Mexico data utilized in this report is GADS data. Dental and pharmacy workforce data is GADS. However, nursing and physician data for New Mexico was taken from other sources, which are in each section.

Physicians supply in NM 2006

New Mexico's citizens depend on an adequate supply of physician services to meet their health care needs. There is much disagreement within the physician workforce literature about what is the "right" or an "adequate" number. However, physicians are the "anchor tenant" in the health care delivery system. Without health care services that can be provided, care is either delayed or not obtained.

This report describes the current physician workforce in New Mexico, the trends in the number, specialty composition, geographic distribution of physicians, and issues related to recruitment and retention of physicians.

The content of this report is in two sections. The first section provides a synopsis of the 2007 physician survey findings and estimations by the Center for Health Workforce Studies (CHWS), University at Albany, State University of New York, School of Public Health. The second section summarizes the Health Policy Commission's physician licensing data from the Geographic Access Database System (GADS).

Physician Survey

The survey resulted with a 50.2% response rate (3,610 responses that could be processed of the 7,196 surveys distributed). Based upon the physician survey and American Medical Association data, the Center for Workforce Studies estimated that there were 3858 active patient physicians in New Mexico in 2007.

The major findings of the survey indicate an improvement in the overall number of physicians in New Mexico. These findings are:

- **Between 2001 and 2006, New Mexico experienced growth in the number of physicians licensed to practice medicine. Comparing the physicians licensed to practice medicine in New Mexico in 2006 to 2001, there were slightly more than 1,000 additional physicians licensed to practice medicine, an increase of 17%.**
- **There were 672 more physicians actually practicing in the state in 2006 than in 2001, an increase of 21%.**
- **This growth accounted for an increase of more than 550 patient care full-time equivalent physicians (FTEs), an increase of more than 22%.**

Other findings include, but are not limited to:

By Demographics

- 69.7% are male and 30.3% are female.

By Ethnicity

- 77.2% are white, 10.7% are Hispanic, 6.3% are Asian or Pacific Islander, 1.4% are African American, 0.7% are Native American or Alaskan native, and 3.7% are multiple or other.

By Gender/Age

- female physicians were significantly younger than male counterparts in 2006 with

a median age of 49 years compared to 55 years among males.

- the median age of active patient care physicians practicing in New Mexico was 53 years.

By Practice Description and Distribution

- 39% are Primary Care Physicians (Family Practice, Internal Medicine, Pediatrics).
- 61% are Specialty and Surgical Care Physicians.

By Primary Practice Location

- 50.3 % are in Bernalillo County,
- 8.8% in Santa Fe County,
- 7.5% in Dona Ana County,
- 4.1% in San Juan County, and
- 29.3% % in the balance of the state.

By Practice Capacity

- about one-fifth of active patient care physicians report that their practices were full and they could not see additional patients.
- three-fifths of the active patient care physicians reported that their practices were nearly full.
- sixteen percent reported that their practices were far from full and could see many additional patients.
- compared to practice capacity in 2001, physician practices in 2006 had greater capacity to see additional patients.

The survey also answered numerous other questions about retention which are addressed in more detail in this report.

Geographic Access Data System Licensure Database

The HPC collects workforce information pursuant to the Health Information System Act (chapter 24, Article 14A NMSA 1978). All state health professional and facility licensing authorities of the State of New Mexico are required under the act to supply to the HPC every quarter, licensure information including demographic, professional education and specialty training data.

There are two important facts that the licensure database confirms. One, the GADS licensing database shows that the actively licensed physician population is growing in absolute numbers. The number of active licenses in the 2001 database was 6,110 while the 2006 figure was 6,565. Second, the licensure data also confirms an aging physician population when compared to 1997 and 2001.

The licensing database has information on all *licensed* allopathic and osteopathic physicians, which does not necessarily signify that the physician is engaged in active *practice* or what the scope of active practice might be, or even if the physician is residing and/or practicing in New Mexico. The last two physician surveys confirm that only about 50 % of New Mexico licensed physicians are actively practicing in New Mexico. Consequently, the utility of the licensure data base is not as precise as what is available in a survey such as the two that have been conducted.

New Mexico Health Policy Commission
2055 South Pacheco Street, Suite 200
Santa Fe, New Mexico 87505
Phone: (505) 827-6201
Fax: (505) 424-3222
www.hpc.state.nm.us