



**NEW MEXICO HEALTH POLICY  
COMMISSION**

**HOUSE JOINT MEMORIAL 61 (2002)**

**Standardize Licensing and Credentialing of  
Health Care Providers Study**

**Final Report**

October 2002



## *Health Policy Commissioners*

Scott Garrett, Chair

Barbara Moore, Vice Chair

Satyra Brown

Felicia Casados

Grace M. Klement

K. Babette Saenz

Donald Silva

Marjorie T. Slaten

**For more information, please contact:**

New Mexico Health Policy Commission

2055 S. Pacheco St., Suite 200

Santa Fe, NM 87505

(505) 424-3200

<http://hpc.state.nm.us>

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## **I. EXECUTIVE SUMMARY**

During the 2001 Legislative Session, Representative Terry Marquardt sponsored a Memorial that asked the NM Health Policy Commission to take the lead in conducting a study to review health care licensing and credentialing in New Mexico, in conjunction with the Department of Health, the Regulation and Licensing department and other affected State Agencies, members of the public and the health care industry. The Memorial was inspired by the extensive duplication and redundancy within the licensing and credentialing processes currently in place in New Mexico. Needless duplication results in costs, delays and burdens that hinder innovation in health care delivery, require providers to struggle with administrative systems and costs that weigh down their practices, and create a formidable barrier to the retention and recruitment of health care professionals in New Mexico.

In response to HJM 61, the HPC launched a study of licensing and credentialing in the state that included a review of what other states are doing on this front, and what some state agencies and organizations have already done to try to streamline their own processes. The bulk of the work on this study, however, was done by the HJM 61 Task Force with HPC facilitation. The Task Force was made up of representatives from all of the licensing boards, as well as key credentialing stakeholders in the state, and met in several working sessions to consider the issues, develop real-time ideas for beginning to address those issues, and to make recommendations to the Legislature.

It should be noted here that while every licensing board was invited to participate in the HJM 61 Task Force, and while representatives from most boards did attend the early meetings of the Task Force, many of the smaller boards did not remain active participants throughout the process and were not directly involved in the creation of the Task Force recommendations. (All board representatives did receive meeting minutes, and were sent copies of the proposed recommendations.) Some of the boards feel that they have few difficulties with the licensing process, and that they may already offer exemplary licensing services. In addition, since they are not directly involved in the credentialing

process, many of the smaller boards did not perceive that process as having a negative impact on them or the providers they licensed. This perspective may not be sufficiently sensitive to the burden on the provider who needs to complete more than one licensing and/or credentialing application – or it may accurately reflect the significantly different licensing and credentialing experiences of the larger and the smaller boards, and of the different health professions they deal with.

That said, a number of boards of various sizes remained active participants throughout the Task Force process. Although the Task Force as a whole approved the set of final recommendations, in general the licensing and credentialing subcommittee recommendations were quite different. The major finding of the Credentialing Subcommittee was that while credentialing is an absolutely critical process in ensuring patient safety, streamlining the process of credential verification is something that could be relatively easy to accomplish with the collaboration and coordination of the various health care providers and organizations in the state. In response to this finding, the Task Force developed a set of recommendations that are primarily focused on education and outreach, and ask very little of the New Mexico Legislature. There is a recommendation to amend NMAC sections related to re-credentialing, to make the time frames consistent with national standards.

The major finding of the Licensing Subcommittee was that while the basic idea of *how* to streamline licensing is fairly obvious – via on-line applications and renewals, involving data bases that can be accessed by a variety of state agencies – the technological complexity of developing the web site, the software, the data base and its protective structure, etc., all require further study and investigation. The primary recommendation of this group is that the Legislature a) allow the Task Force to continue its work and b) provide funding for a project manager who could help the Task Force determine the technological and cost frameworks for its ideas.

The full set of Task Force recommendations includes other issues, most notably the need for increased legislative appropriations to the boards to provide them the staff necessary

to make the transitions they envision. In short, then, this study and report fully respond to the concerns raised by HJM 61, and provides the Legislature with insightful and useful information and recommendations that can be used to streamline the licensing and credentialing process in New Mexico, thus easing the burden on providers and ultimately improving access to health care for all New Mexicans.



## **II. BACKGROUND**

### **The Issue**

The State has a vested interest in protecting public safety by ensuring that the health care professionals at work in New Mexico are qualified and competent in their fields. This concern with patient safety and the quality of health care is the primary reason for licensing health professionals. Credentialing is a similar process with a similar purpose: health care organizations, such as hospitals and other institutions, as well as the managed care and insurance organizations, also seek to protect the safety of their clients/patients by independently verifying the credentials of every health care professional they employ, contract with, and/or reimburse.

Despite the best intentions of both of these processes, they can pose quite a burden for the health care professional, who must provide the licensing board with one set of application materials and verification of his or her qualifications in order to be licensed, and also provide an application and credential verification information to each and every institution and MCO he or she wishes to work with. Providers must also be periodically re-credentialed, which requires yet another round of applications. To make matters worse, each entity has its own application form and its own rules and regulations about application procedures, and generally, each requires original copies of foundation documents such as transcripts, exam scores and the like. It generally takes no small amount of time to acquire original documents from their sources, which adds to the time it takes to complete an application. Once complete, each application takes time to process, which for some health professions means anywhere from a few weeks to months of waiting to be licensed or credentialed.

For the State, as for hospitals and MCOs, the duplication and redundancy is costly and inefficient. For the health care professional, the paperwork alone can be overwhelming, and the waiting time can be economically difficult. The burden created by these processes can be so great as to be a disincentive for health care providers to locate and

practice in New Mexico, which defeats the original purpose of both licensing and credentialing: to provide better health care for all New Mexicans.

## **HJM 61**

The Healthcare Workforce Conference, held in June, 2001, identified the difficulties with licensing and credentialing as a key workforce issue. The final *Report of the Healthcare Workforce Conference* made several recommendations to streamline and coordinate licensing and credentialing of health professionals including:

- Facilitate development of collaborative health professional credentialing efforts;
- Streamline/standardize State credentialing requirements;
- Conduct a study of State licensing processes;
- Examine possibilities for multi-state licensing;
- Review potential for new/expanded health professional practice; and
- Create a competency-based licensing/certification process.

The *Report of the Healthcare Workforce Conference* also recommended improvement of State health workforce data systems, through the coordination and improvement of the ongoing health professional data collection systems of the State's licensing agencies and other related bodies.

In response to these identified problems, Representative Marquardt sponsored House Joint Memorial 61 in the 2001 Legislative Session. The Memorial found that there was a need for a comprehensive review of the current system in order to simplify and consolidate licensing and credentialing, and requested that the Health Policy Commission conduct a study of licensing and credentialing in New Mexico. The study was to give particular attention to:

- The feasibility and desirability of coordination of health care provider licensing and credentialing;
- The collection and maintenance of health care provider licensing and credentialing data;
- Multi-state licensing and reciprocity in licensing; and

- The reduction of duplicative requirements by the establishment of uniform requirements for credentialing.

### **HPC Response to HJM 61**

The HPC took several steps to respond to HJM 61. An environmental scan was completed of the licensing and credentialing processes used in other states, looking for specific examples of approaches that streamline and simplify the processes. An in-state environmental scan was done to identify the various initiatives already underway by some boards to address the problems of duplication and a burdensome system. Finally, the HPC pulled together a Task Force with representatives from all of the State Licensing and Credentialing entities. These agencies very rarely, if ever, have had the opportunity to sit down across the table from one another and discuss their mutual challenges and their various solutions, and the Task Force meetings were very productive.

The final recommendations of the Task Force are the result of hours of debate and discussion at Task Force and subcommittee meetings, as well as untold hours of conversations and deliberations that took place outside the formal proceedings. Some of the recommendations request Legislative action, some request or encourage actions from non-governmental entities. All demonstrate the commitment of Task Force members to work together to improve licensing and credentialing in New Mexico.



### **III. THE ENVIRONMENTAL SCAN**

#### **A. Related Issues Of Health Care Workforce Regulation**

The Pew Health Professions Commission Taskforce on Health Regulation recommended the following with regard to licensing:

- States should standardize entry-to-practice requirements and limit them to competence assessments for health professions to facilitate the physical and professional mobility of the health professions.
- Boards should cooperate with other public and private organizations in collecting data on regulated health professions to support effective workforce planning.
- States should develop evaluation tools that assess the objectives, successes and shortcomings of their regulatory systems and bodies to best protect and promote the public's health.
- States should understand the links, overlaps and conflicts between their health care workforce regulatory systems and other systems which affect the education, regulation and practice of health care practitioners and work to develop partnerships to streamline regulatory structures and processes.<sup>1</sup>

#### **B. Health Professional Licensing in Other States**

Some states have developed licensing and credentialing systems that are more centralized, and hence more streamlined, than the New Mexican system. Three states – Illinois, Nebraska and New York – have regulatory systems run by an agency with Boards acting only in an advisory capacity. Six other states – Connecticut, Florida, Maine, Michigan, Utah and Washington – have Boards that are not fully autonomous, meaning that they don't have final decision making authority on all substantive matters, and certain Board actions are subject to review by a central agency.<sup>2</sup>

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<sup>1</sup> Pew Health Professions Commission Taskforce on Health Regulation. 1995.

<sup>2</sup> Benjamin Shimberg and Doug Roederer. 1994. *Questions a Legislator Should Ask*. Second Edition. The Council on Licensure, Enforcement and Regulation (CLEAR).

The Indiana Health Professions Bureau (HPB) is a single agency that provides professional support services to Indiana's Health Regulatory Boards and Committees, in furtherance of their responsibility to assure the safe and competent delivery of health care to the citizens of Indiana. The HPB licenses health care professionals, and its respective boards discipline practitioners when necessary. The Health Professions Bureau contains specific license information for over 30 different types of health related professionals.<sup>3</sup>

The Virginia Department of Health Professions and the Nebraska Health and Human Services Licensing and Credentialing Division are similar agencies, serving much the same function by coordinating health professional licensing boards and bureaus to assure the safe and competent delivery of health care. These agencies provide information and support for the following activities of the health regulatory boards:

- Licensing applicants who meet minimum qualifications as determined by law and regulation;
- Taking appropriate action to enforce compliance with legal requirements;
- Issuing licenses or permits to certain health related businesses and inspecting for compliance with applicable laws and regulations;
- Studying and recommending the appropriate degree of regulation of health related professions and occupations; and
- Enforcing standards to assure safety and integrity of drugs and medical devices.<sup>4</sup>

The Florida Department of Health has developed CoreSTAT, an Internet database containing core credentialing information for Florida's health care practitioners, licensed or applying for licensure. CoreSTAT is managed by the Florida Division of Medical Quality Assurance (MQA), the agency responsible for licensing Florida practitioners. CoreSTAT was developed in response to Florida physician demands for standardized credentialing. The program reduces the administrative burden of credentialing on

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<sup>3</sup> Information about the Indiana HPB is available on line at: [www.in.gov/hpb](http://www.in.gov/hpb)

<sup>4</sup> Information about the Virginia DHP is available on line at: [www.dhp.state.va.us/aboutdhp.htm](http://www.dhp.state.va.us/aboutdhp.htm)

Information about the Nebraska HHS Credentialing Division is available on line at [www.nhs.state.ne.us/crl/](http://www.nhs.state.ne.us/crl/)

practitioners by creating a central repository of practitioner professional data. Practitioners can now authorize their affiliated health care entities (HCE) or credentialing verification organizations (CVO) to obtain their credentials directly from CoreSTAT.<sup>5</sup>

### **C. The Licensing and Credentialing Process in NM**

One of the first steps taken by each of the Task Force subcommittees was to develop graphic representations of the basic licensing and credentialing process in New Mexico. *Figure 1* represents the “generic” process, *figure 2* portrays the process followed by physicians, and *figure 3* portrays the process followed by nurses (see pages 19, 22 and 23 below). The flow charts allowed each of the participants to consider what sort of process is used by their own agency, and to see just where duplication and overlap is occurring. For some boards, it was a learning experience to come to understand the length and complexity of the licensing and credentialing process required of some providers – several of the smaller boards currently have much simpler licensing procedures, and not all of the health professions in New Mexico require credentialing. However, these smaller boards will likely soon find themselves shifting to more complex licensing processes as their various disciplines expand within the state, and a greater variety of health care professionals will likely soon find that they must go through the credentialing process in order to participate in managed care.

### **D. Initiatives to Streamline the Licensing and Credentialing Process**

Prior to passage of HJM 61, many boards and agencies were already working on their own to try to improve the licensing and credentialing process. During Task Force discussions, each board and credentialing agency highlighted its commitment to protecting public safety by conducting careful and thorough licensing and credentialing – and each also highlighted its efforts to make that process less onerous and burdensome, so that health professionals can be brought on-line in New Mexico as rapidly as possible to meet the growing needs of the state. These individual initiatives laid much of the groundwork for HJM 61. Once the various groups got together within the HJM 61 Task

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<sup>5</sup> Information about the Florida Division of Medical Quality Assurance is available on line at: [www.doh.state.fl.us/mqa](http://www.doh.state.fl.us/mqa)

Force they were able to discuss and compare their efforts with one another, so that individual initiatives could have the potential of becoming shared, successful reforms.<sup>6</sup>

### **NM Board of Medical Examiners (BME)**

BME has taken several steps to address problems identified within the licensing process. BME has proposed rule changes that will streamline the licensing of physicians who are licensed in another state, and who have met the basic requirements for licensure, are board certified, and have no adverse actions against their license. The proposed rule changes will allow such a physician to be licensed in New Mexico without having to go through the time-consuming process of providing original documents, such as transcripts, exam scores and proof of post-graduate training, as long as another state will attest that they have the originals on file.

In May of this year, BME began allowing applicants for licensure to apply directly to BME, rather than requiring that all applicants provide their original documents through the Federation of State Medical Credential Verification Service (FCVS). This initiative is meant to reduce the amount of time it takes BME to issue a license. It takes an average of 78 days for BME to receive an applicant's FCVS report, which might still not provide all the information necessary for licensure. For some applicants, such as a physician who wants to send licensing information to several different states, having a central file at FCVS may save considerable time compared to applying to each state separately. However, for a local, uncomplicated application BME should be faster - if staff can keep up with the new influx of documents. In fact, at the time of this report, BME had just issued a license in 8 days, with several others nearly ready to issue in about 30 days.

Another time-saving BME proposed rule change would allow the Board to accept source documents directly (i.e. transcripts from the school), from FCVS, or from Health Services Corporation (HSC), since applicants who will practice in NM generally use HSC for credentialing purposes.

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<sup>6</sup> Information about the initiatives described in this section was gathered through personal communication with the boards and with HSC staff.

The other BME initiative that has expedited licensing is the issuance of Telemedicine licenses for physicians located in another state who are treating patients located in NM. These licenses can be issued within days of receipt of the few required documents.

### **NM Board of Nursing**

The NM Board of Nursing (BON) has made several efforts to streamline its process of licensing nurses. Two of its initiatives involve proposed legislative action. BON has proposed to delete the section of the Nursing Practice Act that requires applicants for license renewal who have not been engaged in nursing for two years or more to provide evidence of completed refresher courses (61-3-24 D). According to BON, few other states have such a requirement and employers are responsible through accreditation mechanisms to assure nurses are competent to practice. Additionally, the Nursing Practice Act and Rules of the Board of Nursing hold the nurse accountable for maintaining competence to practice. BON is also recommending that legislation be passed to allow New Mexico to participate in the National Council of State Boards of Nursing interstate compact for nursing licensure. This compact, which currently has 18 participating states, will allow nurses who are currently licensed in another state to have a practice privilege in New Mexico without needing to process a licensure application.

Internal changes initiated by BON to speed licensure include:

- Conference call meetings of the Board between regularly scheduled meetings when necessary;
- Revision of application forms to assure that only essential information is requested;
- Preparing to place all application forms on-line for down-loading;
- Relieving clerical staff from phone and other duties for a dedicated period of time for uninterrupted work devoted to the licensure and certification process;
- Planning to fill a vacant clerk supervisor position with a clerk specialist, which will increase the manpower assigned to the actual licensure processing;
- Bringing in-house the evaluation of the transcripts of foreign graduates applying to take the licensure examination and registered nurses seeking endorsement into NM who were educated in foreign nursing school, licensed in another jurisdiction and

successfully passed the NCLEX (national licensure exam). This process was being done by the Commission of Graduate of Foreign Nursing Schools, which lengthened the process of licensure by as much as six months in some cases.

- Looking into the feasibility/legality of using FAX and/or email communication to employers regarding temporary licenses and graduate permits to practice, which would cut down on mailing and delivery time;
- Suspending the rule requiring criminal background checks be completed before licensure, which significantly delayed the licensing process. BON determined that in the 6 months since the inception of the rule, only one nurse was found to have a felony conviction. Suspension of the rule allows a license to be issued prior to receiving the background check, and if a licensee is found to have a felony conviction, he or she will be processed through the disciplinary route.

In addition to these time-saving initiatives, BON began issuing temporary licenses under a number of circumstances, which allows nurses to begin working more quickly – which in turn encourages them to remain in the state. For example, temporary licenses and graduate permits to practice may be issued if the application is not totally complete, i.e. missing a mother's maiden name or a middle initial/name. Of course, permanent licensure to practice will not be issued until all data is received. Temporary permits will also be issued when a license from another jurisdiction can be verified on-line or through NURSYS (national data bank), and when an advanced practice nurse (CNP, CNS, CRNA) qualifies for a temporary license as a registered nurse, a temporary permit for advanced practice will now be issued.

Anticipating the Internet-based future of licensing and credentialing, BON's website continues to be developed and more information is being added. A FAQ section regarding the licensure process is planned.

### **Hospital Services Corporation**

Hospital Services Corporation (HSC), a subsidiary of the New Mexico Hospitals and Health Systems Association, operates as a credentialing agency for a number of health

care organizations. Based on its experience with the multitude of applications and forms required by different organizations around the state, HSC worked for 5 years with the New Mexico Medical Society, the New Mexico Association of Health Plans, and hospitals and physicians throughout the state to develop a single statewide credentialing verification application, which is now used by about 75% of New Mexican hospitals (see Appendix E, page 46, for a complete list). HSC has been working to further the voluntary use of this form throughout New Mexico, to streamline the credentials verification process for New Mexico physicians and practitioners.

All participating organizations maintain independent credentialing responsibility and autonomous decision-making authority. However, these organizations have agreed to move their physicians belonging to more than one of the listed organizations to one shared re-credentialing date every two years to ease the administrative burden placed on physicians. What this means for physicians is that one application, the New Mexico Statewide Application for Physician/Practitioner Appointment, will be used for multiple organizations to credential a physician, reducing the duplicative applications, releases, and verifications used during the credentials/appointment process for those participating organizations.

Physicians may obtain an electronic version of the Statewide Application by accessing HSC's website at [www.nmhsc.com](http://www.nmhsc.com). They can also contact HSC to request that the application be e-mailed or placed on disk and mailed, allowing them to maintain current copies of their application for future updates.

### **Regulation and Licensing Department**

The Regulation and Licensing Department (RLD) has also taken steps to improve its services. The Boards and Commissions Section of RLD sends customer satisfaction surveys to all initial licensees, and regularly integrates feedback into its procedures. RLD representatives on the Task Force note that based on these surveys, the combined overall service rating of all the boards is about an 8 out of a possible perfect score of 10. Further,

many of the boards have 3 – 5 day turn-arounds from receipt of a completed application until a license is issued, and the average maximum for all the boards is about 15 days.

Many boards have difficulty processing applications because it takes a while for the provider to complete his or her application file, for the necessary supporting documents to arrive, etc. The RLD staff for the Optometry, Respiratory Care Advisory and Nursing Home Administrators Boards pride themselves on remaining in contact with applicants throughout this sometimes frustrating process, providing them with a checklist of items in their file and items yet to arrive so that individuals can track the progress of their own application.

The most innovative initiative taken within RLD is the Occupational Therapy Board's on-line license renewal system, which is set to begin on September 23, 2002. Many of the RLD boards have comprehensive web sites that provide information on their licensing process as well as information on other board activities, such as disciplinary oversight, and all of the boards are scheduled to have on-line capacity for applications, renewals and address changes by the end of 2003.

With this level of performance, RLD ranks above many states in the expediency and courtesy of its licensure process. In fact, several of the RLD boards made it clear during the HJM 61 process that they felt that the problems identified in the Memorial are not problems they share.

## **IV. TASK FORCE ISSUES**

As noted above, the HPC's response to HJM 61 included creating a Task Force of representatives from the boards and health organizations directly involved in and impacted by the licensing and credentialing processes (see list in Appendix B, page 37). The Task Force was charged with examining the issues identified by HJM 61 and developing recommendations for the Legislature. Because licensing and credentialing are such different processes, two subcommittees were formed to consider the different challenges they pose. Each subcommittee developed its own recommendations, which were debated and voted on by the full Task Force at its final meeting in September.

After the September meeting, however, several of the boards that were at the first Task Force meetings but were not represented at that final meeting contacted HPC staff to express their own thoughts on the final Task Force recommendations. Those communications are summarized at the end of this section.

### **A. Credentialing Subcommittee**

The complete report of the findings and recommendations of this subcommittee can be found in Appendix C, page 39.

This subcommittee began by considering the following questions:

- What is the purpose of credentialing?
- What is the general process of credentialing health care providers in New Mexico?
- Are there different credentialing processes for hospitals and health care plans?
- Where does credentialing fit within licensing?
- How can the cumbersome process of credentialing be streamlined?
- What steps can be taken to decrease the burden of having to supply and resupply information for multiple types of credentialing?
- Who are the users of this information? Who has access to this information?

One of the key concerns of this subcommittee was the general perception that the value and purpose of credentialing are misunderstood. At its first meeting, the subcommittee worked to clarify the purpose of credentialing, which is often represented as simply a process a provider must go through to receive reimbursement from a hospital or health plan. While credentialing is indeed required for reimbursement, as well as to gain the privilege of practicing at individual health care facilities, its primary purpose is to establish due diligence and concern about the quality and safety of health care provided to health plan members and hospital patients. The subcommittee felt strongly that there is a need for more education of providers and others in the health care field about the value and importance of credentialing in achieving quality medical care.

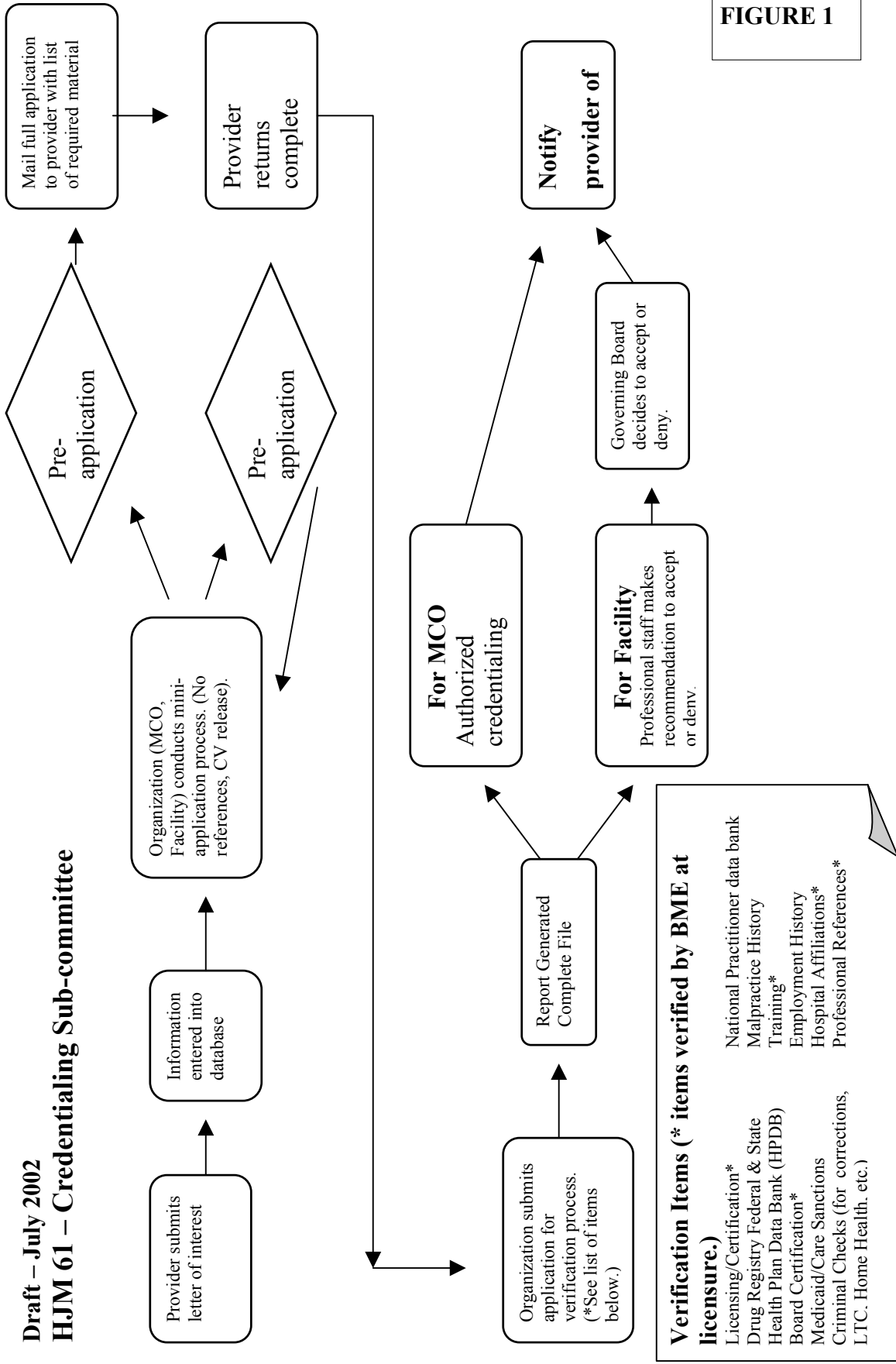
The second major focus of the Credentialing Subcommittee was a determination to reduce the amount of paperwork providers have to submit to the various credentialing and licensing agencies. The subcommittee began by developing a flow chart for the credentialing process, which can be found in *Figure 1*, page 19. The subcommittee then searched for areas of overlap between the credentialing and licensing processes. For example, BME collects transcripts, education assurances, information concerning leaves of absences, disciplinary actions, etc., all of which must be notarized original documents. Some of this same information is needed for credentialing, and it, too, must be in the form of original documents.

The subcommittee discussed the possibility of creating some sort of a central repository for original information, so that a provider would only have to submit one set of documents that could then be kept on file and accessed by any licensing or credentialing agency. However, the subcommittee was not in favor of creating a new State agency for this purpose, and instead decided to concentrate its efforts on the creation of a single application form that could be used by both licensing and credentialing entities. It was quickly agreed that such a form would have more information than any one entity would need, in order to contain all the data fields needed by all the agencies, but that having a statewide form would make life easier for most providers. HSC volunteered its own statewide form, which is the result of years of collaboration with the New Mexico

**Figure 1 – Generic Credentialing Process**

**Draft – July 2002**

**HJMJ 61 – Credentialing Sub-committee**



**FIGURE 1**

Medical Society, the New Mexico Association of Health Plans, and hospitals and physicians throughout the state, and BME and HSC agreed to work together on a pilot project to create a form that both agencies could use.

The third area that this subcommittee focused its efforts on was to identify sections of statute or regulation that need to be changed to facilitate a more streamlined credentialing and licensing process. The subcommittee determined that the New Mexico Administrative Code is inconsistent with NCQA standards in several ways, most notably that NMAC 13.10.13.13 requires re-credentialing every *two* years, while NCQA requires re-credentialing every *three* years. This means that providers are, again, put in the position of supplying the same original documents to one agency one year and the other agency the next year. One of the recommendations of the Task Force then is a set of amendments to create consistency between State regulations and NCQA standards.

## **B. Licensing Subcommittee**

The complete report of the findings and recommendations of this subcommittee can be found in Appendix D, page 43.

This subcommittee began by considering the following questions:

- How can the licensing boards work together to streamline the licensing process, and yet retain their own autonomy?
- Should the boards remain within RLD, or is there an alternate way of organizing them that would help to expedite licensing, such as making each of them an independent agency?
- What is the potential for multi-state reciprocity, compacts or licensing by endorsement that would speed the process of licensing for providers interested in moving to New Mexico from other states?
- What are the specific limitations experienced by the boards that slow the licensing process?

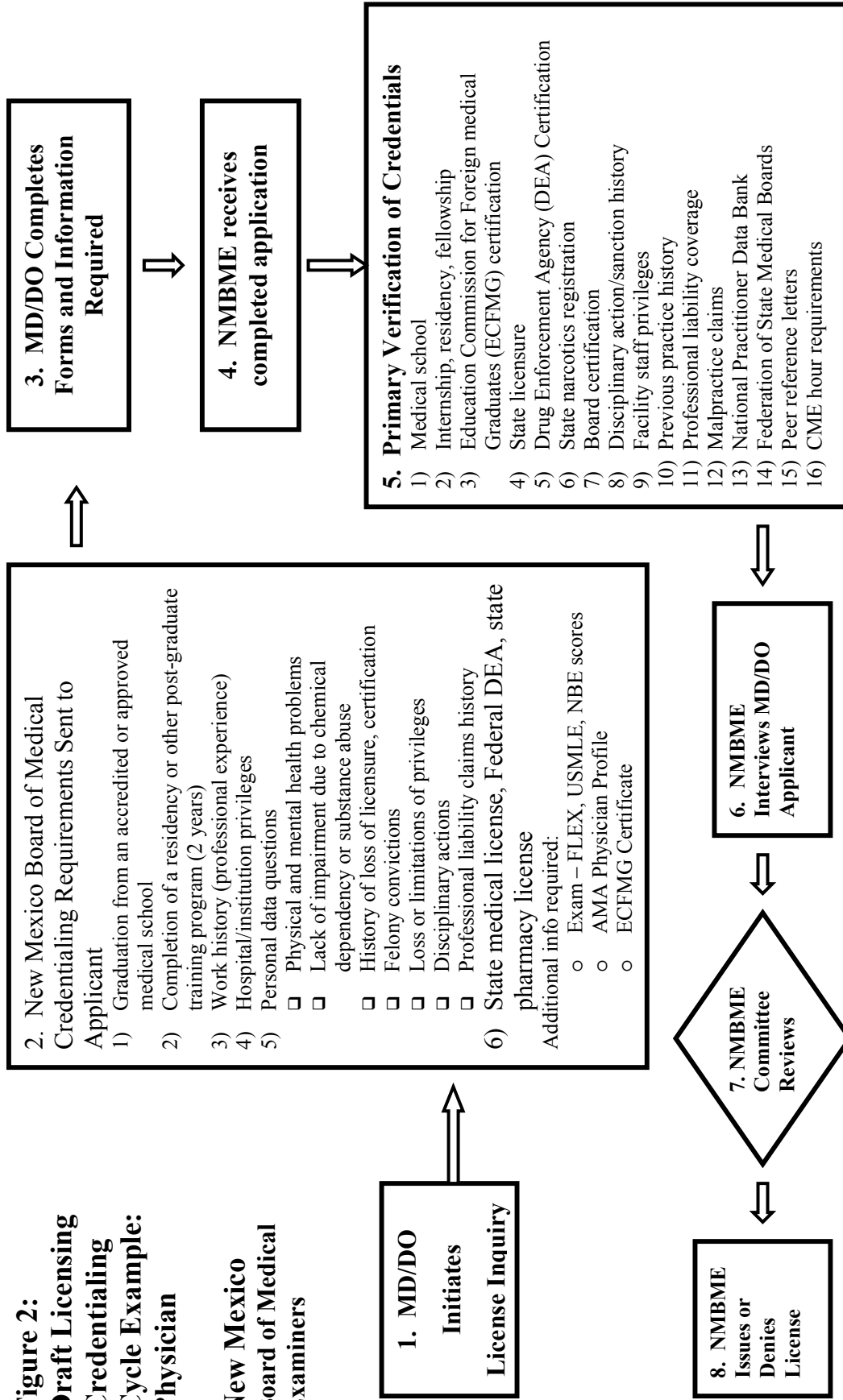
The Licensing Subcommittee began its work by developing a flow chart of the licensing cycle, using physician licensing as an example. (See *Figure 2*, page 22. HPC staff later developed a similar flow chart for nurse licensure, see *Figure 3*, page 23). One of the first conclusions reached by this subcommittee was that there are numerous factors that can make the licensing process frustratingly long for the provider. Some of these factors are:

- Resources: many boards simply do not have the staff necessary to process applications quickly, and some lack sufficient computer and software resources as well.
- Statutory mandates, such as criminal background checks, can slow the process down significantly in way that the board staff have no control over.
- Notarized signatures: apparently, the different boards have different understandings about the legal necessity of notarized signatures. BON does not require them, RLD will accept an on-line renewal application but not finalize it until a signature card is received, and the Board of Pharmacy accepts credit cards over the Internet as a legal signature.
- Board meetings: the requirement that boards meet to approve applications slows the process down because the boards only meet periodically.
- Incomplete applications: subcommittee members felt that neither providers nor Legislators are fully aware of how long it takes to receive supporting documentation from other organizations and facilities, and all of these documents must be received before board staff can begin to process an application.

Given the wide variety of “bumps in the road” identified by the Licensing Subcommittee, the group agreed that the automation of information would be the single most useful step in expediting the licensing process. Applications, supporting documents, and even letters of reference could be transmitted electronically, saving substantial time in the process of building a complete application. Board web sites need to have applications and other

**Figure 2:  
Draft Licensing  
Cycle Example:  
Physician**

**New Mexico  
Board of Medical  
Examiners**



**Figure 2**

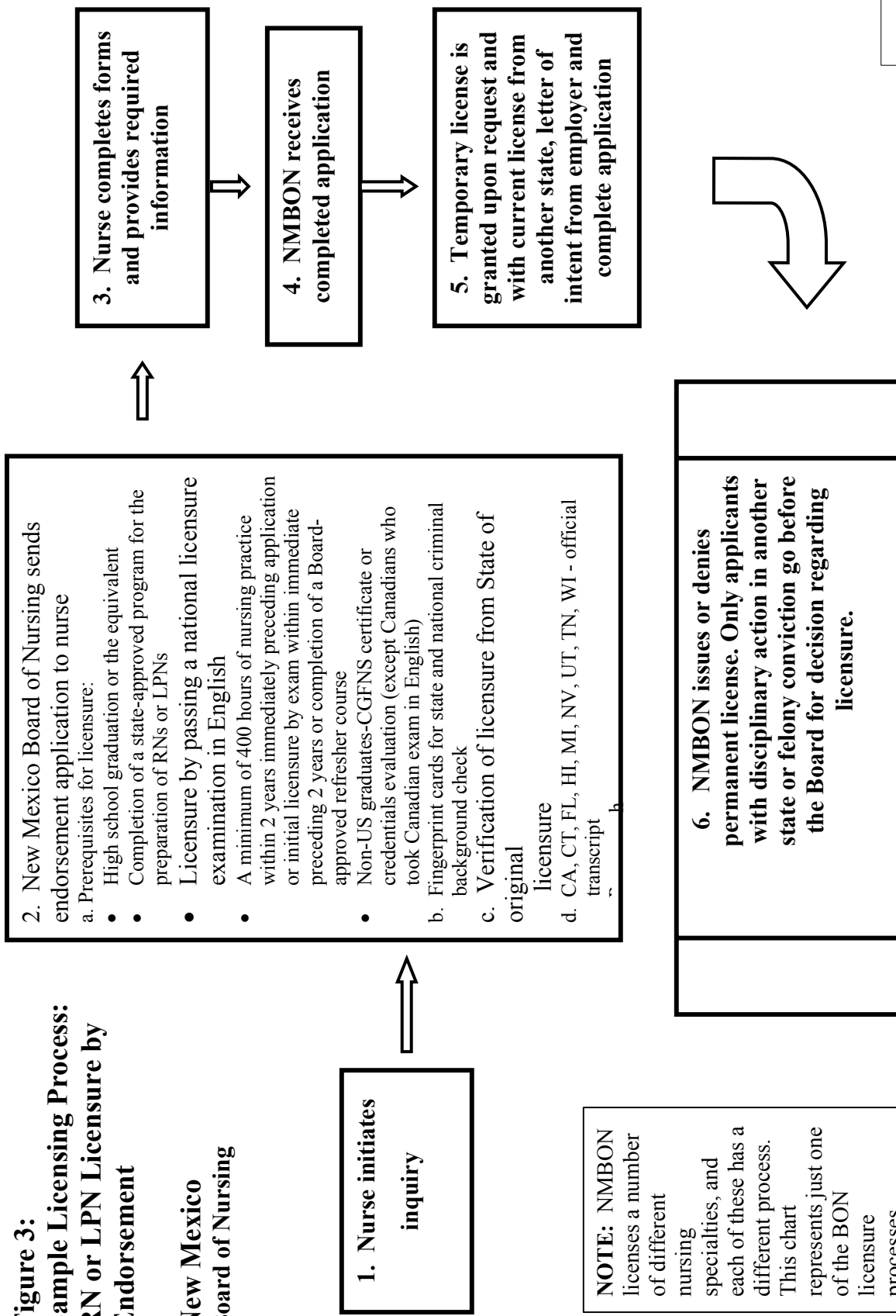
**Recommendations to Simplify and Streamline Licensing/Credentialing:**

- 1) Automate via web interface steps 1 – 4
- 2) Create a uniform data set for licensing and credentialing
- 3) Place all required info and forms on web for electronic completion
- 4) Submit letters of recommendation via web; standardize key elements of letters

Draft 7/28/02  
Dan Derksen, MD  
HJM 61 Task Force

**Figure 3:  
Sample Licensing Process:  
RN or LPN Licensure by  
Endorsement**

**New Mexico  
Board of Nursing**



**NOTE:** NMBON licenses a number of different nursing specialties, and each of these has a different process. This chart represents just one of the BON licensure processes.

**Figure 3**

information that providers can easily download, and ultimately offer automated on-line applications and renewals.

Then the subcommittee turned to considering the turn around times for licensing once an application is complete. There was considerable discussion about whether an “ideal” turn around time could be established for all of the boards, but this idea was dismissed by the subcommittee because each of the boards has different application requirements.

However, the boards can and should each develop their own optimal time cycle, with benchmarks, for application processing. Each board should develop, document and utilize its own set of Best Practices.

The subcommittee discussed the issue of expedited licensing by endorsement, which would also speed turn around times. The Board of Pharmacy and Board of Nursing both offered advances their disciplines have made along this line as models for discussion. The National Board of Pharmacy has created a national exam that pharmacists can take for licensure, and that exam currently has reciprocity in 48 states. Once a pharmacist passes the exam, a license in any state only takes minutes to issue. The New Mexico Board of Pharmacy requires only a provider’s exam score and records of any disciplinary actions in other states, both of which can be electronically transferred from the National Board of Pharmacy, in order to grant a license to a pharmacist moving into New Mexico. The Board of Nursing noted that the Boards of Nursing around the country have come up with an interstate compact for licensure for nurses, to avoid the complicated and lengthy process of having to be licensed in several states. Under this compact, nurses have to hold a license in the state in which they reside. Then they are issued a practice privilege in every other participating state. To date, 18 states have signed on, and BON has made a proposal to the Legislature that it be allowed to join the compact as well.

Other subcommittee members questioned the value of multi-state reciprocity agreements, arguing that variations in state requirements for licensure, grandfather clauses, and challenges posed by establishing licensing requirements for the new health professional fields created by reform, such as physician assistants and apprentices, all mitigate against

wholesale licensing by endorsement. This issue engendered much discussion, but the subcommittee reached no particular conclusion and offered no recommendation on the topic.

Ultimately, licensing board representatives agreed that their discussions were educational and beneficial, but they also agreed that there are significant differences between the boards. There were concerns that decisions might be made by the Task Force to address the difficulties experienced by *some* boards, that would have the consequence of negatively impacting other boards *not* experiencing problems. It was agreed that any recommendations from the Licensing Subcommittee should be general in nature, and that the individual boards would ultimately choose what was appropriate for their own situations. For example, the subcommittee had extensive discussions about the development and use of a statewide application form, and considered possible data fields for inclusion on that form, but was unable to conclusively agree that they would all use the form. Voluntary use of the statewide application will be encouraged, but the subcommittee determined not to attempt or recommend any sort of mandated form.

### **C. Other points of view**

As noted above, while the Task Force initially included representatives from nearly every licensing board, attendance declined and the final subcommittee and Task Force recommendations were ultimately approved by a smaller group of Task Force members. All Task Force members regularly received meeting notices and minutes, whether they attended meetings or not, so that everyone would be kept abreast of the progress being made by the group. Few comments were received in response to the various meeting minutes, however when HPC circulated the recommendations adopted at the final Task Force meeting, several board representatives responded with concern.<sup>7</sup> These concerns fell into two categories.

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<sup>7</sup> The comments presented in this section are drawn from personal communication between HPC staff and board representatives. Specific boards and individuals are not identified, because while these individuals communicated openly with HPC staff, they had no expectation that their comments would appear directly in this report.

The first area of concern was that the issue of separating the boards from RLD had not been addressed definitively enough:

“Through RLD our boards have been able to publish comprehensive Websites that provide information on many aspects of the licensing process in addition to licensee search and disciplinary information capabilities; and RLD provides the Webmasters to update our Websites as requested by each Board's staff.

Through RLD, our boards have access to a Management Information Systems team that many of these smaller boards would not ever begin to have access to due to financial constraints.

Through RLD, we have access to administrative services that assist us in processing our financial documents in an accurate manner acceptable to the Department of Finance and Administration.

Through RLD, we have access to Human Resources staff to process employee "paperwork", thus leaving time for Board staff to actually deal with the licensing, regulatory, and disciplinary processes that boards deal with daily.

[The] boards are very aware that outside of RLD, their job would be more complicated, more expensive, less efficient. They also know that if they were separated from RLD, they would have to increase their fees significantly in order to continue the same level of operation and maintain the quality of customer service currently being provided. They were all very vocal against being made independent boards when Governor Johnson introduced that legislative initiative several years ago, and they maintain the same position today .... some of the boards are very small (small licensee bases) and cannot afford to raise their fees much more without experiencing a drop further in licensee numbers. Some of these small boards need financial assistance from the Legislature to continue to do the job they were called on to do. If they were independent boards ... they would be unable to continue operation. Sharing staff and resources is their only hope for survival! RLD is their lifesaver.”

The second area of concern was that the recommendations reflected the needs of the larger boards, and are not relevant to the smaller boards:

“I believe the Legislature should focus more of their efforts on the particular professions from which the complaints arise.”

“I find it difficult to believe that we are going to create another licensing agency or part of government when the majority of credentialing problems are associated with only one Board.”

Some of the boards clearly feel that they have few difficulties with the licensing process, and that they already offer exemplary licensing services. In addition, since they are not directly involved in the credentialing process, many of the smaller boards did not perceive that process as having a negative impact on them or the providers they licensed. This perspective may or may not be sufficiently sensitive to the burden on the provider who needs to complete more than one licensing and/or credentialing application, and it may or may not accurately reflect the significantly different licensing and credentialing experiences of the larger and the smaller boards, and of the different health professions they deal with.



## VI. RECOMMENDATIONS TO THE NEW MEXICO LEGISLATURE

### A. FINAL HJM 61 TASK FORCE RECOMMENDATIONS

#### Final Task Force Recommendations

The Task Force adopted all of the Credentialing Committee's recommendations:

- BME and HSC should continue their efforts at barrier reduction and work together to coordinate and streamline licensing and credentialing.
- State licensing boards should establish links on their web sites to the HSC statewide standard credential verification form.
- A press release should be issued by the Health Policy Commission following the conclusion of the work of the HJM 61 Task Force, to result in an article in the *Albuquerque Journal*. The press release should summarize the work of the Task Force, and emphasize several important issues: the ways in which a standard form would help expedite patient care, reduce barriers, limit processing delays, speed reimbursement and improve recruitment in the state by reducing the burden on providers; and the equally important need for providers to be certain that their applications are complete before submitting them, in order to reduce processing delays caused by incomplete applications.
- The NM Hospital Association should send a letter to all the organizations that are not using the statewide form. The letter should stress the ways in which a standard form would ease the process of credentialing, improve retention, reduce the burden on providers, expedite reimbursement, improve patient care, etc. BME's acceptance of the form should be mentioned. Organizations should be encouraged to use the form, perhaps in a pilot program, which they could customize with their own logo, etc. If they feel they cannot change to using the standard form, they should be encouraged to at least accept it, as well as to accept forms from other organizations. Finally, the letter should invite feed back from the organizations about their

experience with the statewide form or their reasons for not using it, so that this issue can be better understood. The letter should be sent to organization CEOs, but also copied to Chiefs of Staff and credentialing staff within each organization.

- Members of the HJM 61 Task Force should be encouraged to make phone calls to people they know in the credentialing world, to discuss the value of using the statewide standard form with them personally.
- The New Mexico Administrative Code should be made consistent with National Committee for Quality Assurance (NCQA) standards to further streamline the credentials process, easing administrative burden on practitioners and providers.
- Specific proposed changes to *NMAC 13.10.13.10* are:

F. 2. Graduation from applicable health professional school or program. Not required if practitioner is board certified.

3. Completion of post graduate training. Not required if practitioner is board certified.

4. Current level of professional liability coverage. Acceptable evidence of policy may come from practitioner's application or face-sheet, or from primary source.

G. At least every ~~two~~ three years, MHCPs shall repeat primary verification of its participating providers and facilities to assure ongoing compliance with this section.

H. 1. The health professional or facility's ~~license history in this and all other states.~~ current license(s).

The Task Force adopted the Licensing Committee recommendations with some changes:

1. To request legislation from the LHHS to either allocate agency cash balances from willing agencies, or for a special appropriation of \$50,000, in FY03 to fund an Information Technology Project Manager to:
  - a. Review current process/software/hardware used in licensure and registration of all healthcare professionals;
  - b. Make recommendations for common hardware/software/procedures for licenses, registration for healthcare professionals; and
  - c. Make recommendations for process/software/hardware requirements for controlled access to healthcare professional data/information.
  
2. To request a Legislative Memorial to continue the work of the cross-agency Task Force for health professional boards of licensure to study the feasibility of:
  - a. Developing a sharable process for on-line electronic health professional licensure/certification/registration;
  - b. Developing a coordinated process/mechanism and protocols allowing controlled access to data/information; and
  - c. Other activities to minimize barriers to health professional licensure/certification/registration as deemed advisable by the Task Force.

The Task Force adopted one new recommendation:

1. To support the licensing boards' requests to the Legislature for additional resources and staffing. Additional resources would improve turn-around time on applications within the existing processes, and would make it possible for the boards to transition to whatever new process(es) might be identified as a result of the continuing work of this Task Force.

## **B. NEW MEXICO HEALTH POLICY COMMISSION RECOMMENDATIONS**

The Commissioners of the NM Health Policy Commission applaud the work of the HJM 61 Task Force. The Commission strongly supports all of the Task Force recommendations as presented, with one modification. The HPC recommends that the proposed Information Technology Project Manager collaborate with the Health Policy Commission, with respect to its role within the Health Information Systems Act, and collaborate as well with other relevant State Agencies and organizations.

The HPC supports the idea that adoption of the statewide application should be primarily voluntary. However, the basic idea of a single statewide application is such a clear step forward that the HPC would like to see the Legislature set a time frame within which State Agencies and other organizations must come into compliance with the statewide application, either by using the HSC form or by making sure that their own application forms contain at a minimum the same basic data set.

## **APPENDICES**



**APPENDIX A: House Joint Memorial 61**

HOUSE JOINT MEMORIAL 61

45th legislature - STATE OF NEW MEXICO - second session, 2002

INTRODUCED BY  
Terry T. Marquardt

FOR THE LEGISLATIVE HEALTH SUBCOMMITTEE

A JOINT MEMORIAL

REQUESTING THAT THE NEW MEXICO HEALTH POLICY COMMISSION CONDUCT A STUDY AND PROVIDE FINDINGS AND RECOMMENDATIONS TO STREAMLINE AND STANDARDIZE THE LICENSING AND CREDENTIALING OF HEALTH CARE PROVIDERS.

WHEREAS, licensing and credentialing of health care providers are essential to ensuring and protecting public health and safety; and

WHEREAS, licensing and credentialing by the state often result in excessive duplication and may hinder innovation in the delivery of health care; and

WHEREAS, licensing and credentialing are costly to the state, and duplicative requirements present considerable burdens to private industry; and

WHEREAS, it is in the interest of the state to promote the development of shared systems for health care provider licensing and credentialing; and

WHEREAS, there is a need for a comprehensive review of current health care provider licensing and certification processes to make recommendations to simplify and consolidate licensing and credentialing; and

WHEREAS, current health care delivery systems and certain electronic health care access points may include out-of-state providers;

NOW, THEREFORE, BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO that the New Mexico health policy commission, in conjunction with the department of health, the regulation and licensing department and other affected state agencies, members of the public and the health care industry, be requested to conduct a study to review health care provider licensing and credentialing; and

BE IT FURTHER RESOLVED that the health care provider licensing and credentialing review include an inventory of all health care provider licensing and credentialing conducted by the state, identifying areas of duplication and overlap; and BE IT FURTHER RESOLVED that the assessment include:

A. the feasibility and desirability of coordination of health care provider licensing and credentialing;

B. the collection and maintenance of health care provider licensing and credentialing information;

C. multistate licensing and reciprocity in licensing; and

D. reducing duplication among state agencies and establishing uniform requirements for credentialing; and

BE IT FURTHER RESOLVED that the New Mexico health policy commission report its findings and recommendations to an appropriate legislative interim committee by October 1, 2002; and

BE IT FURTHER RESOLVED that a copy of this memorial be transmitted to the New Mexico health policy commission.

## **APPENDIX B: HJM 61 Task Force Members**

Becky Armijo-Lakey – NM Speech Language Pathology, Audiology & Hearing  
Eva Baca – NM Counseling & Therapy Practice Board  
Kristi Beck – NM Health Services Corporation  
Chris Begay Vining – NMSHA  
Debra Brady – NM Board of Nursing  
Kevin Caffrey – NM Speech Language and Hearing Association  
Wanda Carrillo – Legislative Finance Committee  
David Casas  
Connie Cody-Maldeggen – NMSHA  
Dan Derksen – UNM Center for Community Partnerships  
Rena DiGregorio – NMHSA  
Jan Grosse - Lovelace Delivery System  
Jerry Harrison – NM Health Resources, Inc.  
Bonnie Hatch– DOH/PHD/Health Systems  
Diana Heider – UNM Center for Community Partnerships  
Maggie Horan – NM Speech Language Pathology, Audiology & Hearing  
Charlotte Kinney – NM Board of Medical Examiners  
Elaine Levine – NM Psychological Association  
Diana Madrid – Cimarron  
Melissa Manlove – NM Health Resources  
Randy Marshall – NM Medical Society  
Mario Marquez – NM Psychiatric Association  
Maria Martinez – Legislative Finance Committee  
Joseph Menapace – NM Dental Association  
William Monthan – Respiratory Care Advisory Board (Chair)  
Jerry Montoya – NM Board of Pharmacy  
Liz Montoya – NM Osteopathic, Podiatry and Chiropractic Examiners Boards  
Richard Montoya – NM Optometric Association  
Rosemarie Ortiz – NM Acupuncture & Oriental Medicine Board  
Brooke Patterson – NM Respiratory Care Society  
Carmen Payne – NM Respiratory Care Practitioners Advisory and Optometry Boards  
Fred Pintz – DOH Office of Facility Management  
Galina Priloutskaya – NM Medical Review Association  
Robert Quintela – NMSRC & Respiratory Care Board Public Member  
Anita Ralstin – NM Nurse Practitioner Council  
Annette Rodriguez – NM Board of Dental Health Care  
Angelina Romero – NM Board of Social Work  
JoAnn Salazar – DOH/PHD/Health Systems  
Mary Schulte – Blue Cross/Blue Shield  
Daniel Silva – NMSRC  
Celeste Skardis – Oriental Medicine Association of New Mexico  
Jeff Varela – Regulation and Licensing Department  
Antoinette Vigil– NM Board of Dental Health Care

JJ Walker – NM Physical Therapists and Occupational Therapy Boards  
Kelly Ward – Regulation & Licensing  
Karen Wells – Legislative Council Service  
Rick Word – Office of the Attorney General

HPC Staff

Beverly Russell  
Dot Ball  
Letty Rutledge  
Jenny Felmley

## **APPENDIX C: Minutes of the final meeting of the Credentialing Subcommittee, including proposed recommendations**

NEW MEXICO HEALTH POLICY COMMISSION  
**HJM 61 Licensing and Credentialing Task Force  
Credentialing Subcommittee**  
Wednesday, August 7, 2002  
2 – 4 pm  
**Meeting Minutes**

**Attendance:** Kristi Beck, Melissa Manlove, Celeste Skardis, Charlotte Kinney, Jan Grosse, Diana Heider, Barbara Mohler, and Jenny Felmley.

### **Discussion**

Subcommittee Chair Kristi Beck welcomed the attendees. The group moved right into the agenda items, the first of which was a comparison of Medicaid and NCQA quality assurance requirements. Ms. Beck said that she had already done an analysis of this subject, and volunteered to email her work to all the subcommittee members.

The next item on the agenda was consideration of the short and long term issues the subcommittee identified at its previous meeting. The first of the short-term issues was the coordination between licensing and credentialing verification organizations, beginning with BME and HSC. Ms. Beck and Ms. Kinney indicated that they are in the process of discussing and working on this issue. They may or may not have any concrete results to share with the Task Force at its last meeting, and they stressed that this is an on-going and productive process.

The second short-term issue was the education of hiring organizations and entities on the value of using a standardized form. The group discussed at some length the methods and conduits for this education, and ultimately decided on a two-step recommendation. The first step should be the issuance by the HPC of a press release and the publication of an article in the *Albuquerque Journal* (and other papers if possible), which would summarize the work of the Task Force, and emphasize several important issues: the ways in which a standard form would help expedite patient care, reduce barriers, limit processing delays, speed reimbursement and improve recruitment in the state by reducing the burden on providers; and the equally important need for providers to be certain that their applications are complete before submitting them, in order to reduce processing delays caused by incomplete applications.

Discussion about the second step in the education process revolved around just how to encourage organizations to use the HSC statewide form. Some people felt that having the

MCOs require the standard form as they renew contracts was the best approach; others felt that using the MCOs to force compliance was a bad idea. Some facilities utilize software that generates its own form, and would be unable to comply without significant difficulty. The idea of keeping the data set the same while allowing the actual forms to differ was discussed, but would still result in providers having to fill out multiple forms. The Locum Tenens program recently did a review of its files and found that, on average, doctors had 6 or 7 different applications in their files. A possible solution might be that organizations could continue to use their own forms, using a standard data set, but accept all other forms – other organizations’ forms as well as the HSC statewide form.

The subcommittee recommendation for this issue was that, after the press release and article, the Hospital Association should send a letter to all the organizations that are not using the statewide form. The letter should stress the ways in which a standard form would ease the process of credentialing, improve retention, reduce the burden on providers, expedite reimbursement, improve patient care, etc. BME’s acceptance of the form should be mentioned. Organizations should be encouraged to use the form, perhaps in a pilot program, which they could customize with their own logo, etc. If they feel they cannot change to using the standard form, they should be encouraged to at least accept it, as well as to accept forms from other organizations. Finally, the letter should invite feedback from the organizations about their experience with the statewide form or their reasons for not using it, so that this issue can be better understood. The group agreed that the letter should be sent to organization CEOs, but also copied to Chiefs of Staff and credentialing staff within each organization. Further, members of the Subcommittee and Task Force should be encouraged to make phone calls to people they know in the credentialing world, to discuss this issue with them personally.

Another recommendation related to the statewide form was that the licensing boards be encouraged to put a link to the form on their web sites, once they have agreed to accept it.

The third short-term issue on the agenda was to develop a brochure or other training tool to educate providers about the credentialing process. However, the group felt that this was an impractical duty for the Task Force to undertake, and that BME and other organizations already provide sufficient information on the topic in their existing literature.

Before moving on to the next issue, there was some discussion of the costs of credential verification, as well as which existing option might be the fastest. There are fees for some transcripts and test scores, though this varies from school to school and from state to state. The Federation Credentials Verification Service (FCVS) in Texas charges \$250 to establish a “base” file, and then charges \$50 for each additional profile. There are also various surcharges for things like exam transcripts, ECFMG certification, passport handling and other administrative fees. (Approximate figures were discussed during the meeting, and verified from the FCVS web site later.) This system is expensive for a doctor working in one state at one facility, but is more cost-effective for doctors who want to work in several states. When providers have their information verified through BME and FCVS, BME charges \$100 and FCVS charges \$250. When only the BME is

involved, the charge is \$350. Recent changes allow the BME to verify source documents, however, many applicants continue to use FCVS because they are unaware of the alternatives. There is a great deal of variation in the speed of processing, which depends not just on verifying entities but also on the complexity of any given provider's application. Because the BME has just started doing verifications it has no real data yet on processing time. So far the process *seems* faster, but BME will need additional resources to continue. The BME is currently considering accepting HSC verification as well as that of any other certified verification service, which would likely speed up the process and give providers more options.

There was a brief discussion of the issue of malpractice insurance rates, and which organizations require that a provider must have malpractice insurance before seeing patients. It was noted that the cap on malpractice settlements only applies to physicians, and could be expanded to cover other disciplines. The group determined that this is an issue relative to recruitment, but not within the scope of this Task Force.

The discussion then turned to the long-term issues on the agenda. The first of these was to review and make changes to regulations affecting credentialing requirements in the State, especially those at the Department of Insurance. The Subcommittee recommendation on this issue is that the Department of Insurance shift to a 3 year cycle for re-verification, to match NCQA and hospital cycles.

The group concluded its discussion by posing the question: What are we saying to the State Legislature? What action, if any, are we requesting from the Legislature? The answer was that the Subcommittee is asking nothing from the Legislature, other than the recommended change for DOI. The stakeholders have responded to the opportunity for discussion provided by HJM 61, and have worked among themselves to address the issues. This cooperative effort satisfies the intent of the Memorial, and should be outcome enough. The Subcommittee expressed very clearly that it is not in favor of greater State involvement in credentialing, whether via new State mandates or regulations, a credentialing franchise or creation of a new State Agency.

## **Recap of Credentialing Subcommittee Recommendations**

### **Regarding the automation of information:**

- BME and HSC should continue their efforts at barrier reduction and work together to coordinate and streamline licensing and credentialing.
- State licensing boards should establish links on their web sites to the HSC statewide standard credential verification form.

**Regarding regulatory and/or statutory change:**

- The Department of Insurance should change its re-verification cycle from 2 years to 3 years, to reduce the burden on providers and simplify the process.

**Regarding provider and health care organization education:**

- A press release should be issued by the Health Policy Commission following the conclusion of the work of the HJM 61 Task Force, to result in an article in the *Albuquerque Journal*. The press release should summarize the work of the Task Force, and emphasize several important issues: the ways in which a standard form would help expedite patient care, reduce barriers, limit processing delays, speed reimbursement and improve recruitment in the state by reducing the burden on providers; and the equally important need for providers to be certain that their applications are complete before submitting them, in order to reduce processing delays caused by incomplete applications.
- The NM Hospital Association should send a letter to all the organizations that are not using the statewide form. The letter should stress the ways in which a standard form would ease the process of credentialing, improve retention, reduce the burden on providers, expedite reimbursement, improve patient care, etc. BME's acceptance of the form should be mentioned. Organizations should be encouraged to use the form, perhaps in a pilot program, which they could customize with their own logo, etc. If they feel they cannot change to using the standard form, they should be encouraged to at least accept it, as well as to accept forms from other organizations. Finally, the letter should invite feed back from the organizations about their experience with the statewide form or their reasons for not using it, so that this issue can be better understood. The letter should be sent to organization CEOs, but also copied to Chiefs of Staff and credentialing staff within each organization.
- Members of the HJM 61 Task Force should be encouraged to make phone calls to people they know in the credentialing world, to discuss the value of using the statewide standard form with them personally.

Minutes respectfully submitted by Jenny Felmley, August 8, 2002.

**APPENDIX D: Minutes of the final meeting of the Licensing Subcommittee, including proposed recommendations**

New Mexico Health Policy Commission  
HJM 61 Subcommittee on Licensing  
Meeting Minutes  
September 3, 2002

Present: Charlotte Kinney, BME; Jerry Harrison, NMHR; Lynn Harris, CIO's Office; Laura Romero, Boards & Commissions/MTB; Carrie Roberts, NMNA; Phyllis Ratliff, BoN; Annette M. Rodriguez, NMBODHC; Antoinette Vigil, NMBODHC; Zack Shandler, NMAGO; Barbara Mohler, NMBME; Thomas R. Rushton, NMPRC; Letty Rutledge, NMHPC

**Called to order 2:10**

**Introductions**

Introductions were made.

**Approval of Agenda**

Agenda was changed to reflect that Lynn Harris was present for the CIO office, and that the Uniform Data Elements would not be discussed because Dr. Derkson was not present.

**Approval of Minutes**

Minutes were approved pending the correction to last sentence on page one; the clearinghouse is PBIS, not PPIS.

**Report from CIO Office on Electronic signatures**

Lynn Harris gave a review of electronic signatures from a historical and practical applications perspective.

- The Federal Digital Signature Act was passed in 1999, which allowed electronic signatures to carry the same weight as an original hard copy signature.
- NM Legislature passed a State version of the Act, which is the same as the Federal version.
- Individuals must be given the choice to use either electronic signatures or a hard copy signature.
- E-signatures come in 2 forms:
  - o *Digital* = encrypted solutions and *electronic signatures* = non encrypted
- Not all signatures are digital but all signatures are electronic.
- Hitting 'accept' on an electronic form counts as e-signature.

**Technical Issues**


- Palm prints can be used as an e-signature.
- E-signatures are used to verify and authenticate the identity of the user/applicant.

- Digital signatures have a built in ability to ensure that the content of a message has not been altered.
- Easiest way to accept an electronic or digital signature is to have the date and time that person sent document.
- E-signatures are encrypted in trillions of codes so that it is difficult for someone else to access the information.
- Verification of signatures --Adobe Acrobat 5.0 full version includes a digital signature with the ability to capture a real signature.
  - o Physicians or applicants must have the full Adobe Acrobat software installed on their own computer for transmission to be possible.
  - o Costs \$29 dollars for a State agency to purchase under contract.
  - o Is different from the Adobe Acrobat Reader.
  - o Other similar software can cost in the millions.
  - o CIO and GSD currently use Adobe for timesheets
  - o Program can also be used to create forms that can be completed online and submitted electronically, however, without the digital signature unless the applicant has the full software.
- Other companies besides Adobe can do this.

#### **How to use**

- Contracts, letters, facilitate financial transactions, time sheets.
- Can't use for some things like adoptions and marriage contracts, etc
- Cuts down process time and cost of processing
- On-line applications can be set up to force applicant to complete every line with the appropriate upper or lower case letter, initials, etc.

#### **Storing the Database and other Financial and Logistical Matters**

The  as extensive discussion about the creation of a system of centralized data storage, where the database could be stored, who would be responsible to manage and implement it, how outside agencies could access the data, and the cost to maintain it. Ms. Harris discussed the ability to block information from one agency to another by setting confidential parameters.

It was suggested that an important part of the process would be to notify applicants that their information may be available to other state agencies. Mr. Shandler said it wouldn't hurt to put a privacy statement on the form, but it is not legally necessary to let applicants know who will have access to their data.

The group brainstormed on how the project could be funded, and it was suggested that a cross agency C-3 application be submitted in next year's IT Strategic Plan. The committee plans to continue meeting throughout this year and the next to develop a conceptual plan for implementing a database sharing system that would reduce duplication and produce cost savings to the State and applicants.

A statewide endeavor/initiative versus coming from individual agencies might be perceived as a positive first step by Legislators. It was stated that the Legislature has historically funded technology projects.

A project manager will need to be hired, and questions arose as to where this individual would work. It was suggested that the GSD could manage the database system, creating firewalls, making backups, fixing software problems, etc. Continued discussion and evaluation is needed to determine the specifics of roles and responsibilities. It was also suggested that cash balances from willing agencies might be used to support a contract with an individual who would do such an analysis.

This project requires that agencies work closely together to identify what the needs of agencies are, to determine common solutions, and come up with a final product.

Another issue was the statewide portal and how it might impact how customers access the various licensing boards. Ms. Harris suggested that links could be set up so that physicians, boards and other things could be found using various search engines. This is an ongoing project of the CIOs office.

#### **Tentative Plans for this Committee**

- Develop a cross agency collaborative plan to use the C-3 form to request a special appropriation for an interagency project. The C-3 form will require identification of system or project cost, and clarification of how system development will be handled.
- Start planning activities as early as possible to determine licensing business needs – everyone who is interested can participate.
- Determine an appropriate place to house the project.
- This committee should work closely with the CIO's office to get their input.

#### **Recommendations to HJM 61 Task Force**

1. To continue working as a cross-agency group through the year to develop a common web-based application form.
2. To maintain the database in central location allowing all internal and external agencies to have controlled access to data/information.
3. To allocate agency cash balances (of willing agencies) to fund a temporary contract with a project manager who will develop a project plan with a high level conceptual model to be presented to the legislature, culminating in a C-3 request September 1, 2003 for a FY05 project.

The question was asked if the HPC would still be able to provide staff support to this meeting.

Committee adjourned at 3:55. Will wait until after the October Legislative Subcommittee hearing to set next meeting.

Minutes respectfully submitted by Letty Rutledge on September 4, 2002.

**APPENDIX E: Health care organizations participating in the HSC centralized credentialing process**

Acoma Canoncito Laguna Hospital	Presbyterian Health Plan
Artesia General Hospital	Presbyterian Medical Services
Aspen Behavioral Health	Radiology Associates of Albuquerque
Ben Archer Community Health Centers	Rio Grande Behavioral Health
BlueCross BlueShield of New Mexico	Sequoyah Adolescent Treatment Center
Cibola General Hospital	Sierra Vista Hospital
Cimarron Health Plan	Snelling Personnel Services
First Choice Community Healthcare	Turquoise Lodge
Ft. Bayard Medical Center	Union County General Hospital
Health Centers of Northern N.M.	
Heart Hospital of New Mexico	
Holy Cross Hospital	
La Casa de Buena Salud	
La Clinica de Familia, Inc.	
La Familia Medical Center	
Las Clinicas Del Norte	
Las Vegas Medical Center	
Lea County PHO	
Lea Regional Medical Center	
Lovelace Health Systems	
Mesilla Valley Hospital	
NM Rehabilitation Center	
NM Rehabilitation Center	
NM Veteran's Center	
Nor-Lea General Hospital	
Preferred Providers of New Mexico	

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## NM Health Policy Commission Staff

Beverly Russell	Deputy Director	<a href="mailto:bevr@hpc.state.nm.us">bevr@hpc.state.nm.us</a>
Patrick Alarid	Management Analyst	<a href="mailto:jpalarid@hpc.state.nm.us">jpalarid@hpc.state.nm.us</a>
Michael Baca	Network & Computer System Admin.	<a href="mailto:mabaca@hpc.state.nm.us">mabaca@hpc.state.nm.us</a>
Joanne Carlsen	Financial Specialist	<a href="mailto:jjcarlsen@hpc.state.nm.us">jjcarlsen@hpc.state.nm.us</a>
Camille Clifford	Computer Systems Analyst	<a href="mailto:cpclifford@hpc.state.nm.us">cpclifford@hpc.state.nm.us</a>
Susan DeGrand	Computer Systems Analyst	<a href="mailto:sldegrand@hpc.state.nm.us">sldegrand@hpc.state.nm.us</a>
Jenny Felmley	Special Projects Assistant	<a href="mailto:jfelmley@hpc.state.nm.us">jfelmley@hpc.state.nm.us</a>
Irma Montoya	Management Analyst	<a href="mailto:ivmontoya@hpc.state.nm.us">ivmontoya@hpc.state.nm.us</a>
Kate Myers	Office and Administrative Support	<a href="mailto:kmyers@hpc.state.nm.us">kmyers@hpc.state.nm.us</a>
Kim Price	Computer Systems Analyst	<a href="mailto:kprice@hpc.state.nm.us">kprice@hpc.state.nm.us</a>
Lori Quintana	Business Operations Specialist	<a href="mailto:lquintana@hpc.state.nm.us">lquintana@hpc.state.nm.us</a>
Leticia Rutledge	Management Analyst	<a href="mailto:lmrutledge@hpc.state.nm.us">lmrutledge@hpc.state.nm.us</a>

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**For more information, please contact:**  
New Mexico Health Policy Commission  
2055 S. Pacheco St., Suite 200  
Santa Fe, NM 87505  
(505) 424-3200  
<http://hpc.state.nm.us>