Report
to
The LEGISLATIVE FINANCE COMMITTEE

Department of Health and Allied Agencies
Adequacy of New Mexico's Healthcare Systems Workforce
May 15, 2013

Report #13-03

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David Abbey
Director

May 15, 2013

Ms. Retta Ward, MPH, Secretary
New Mexico Department of Health
1190 S. St. Francis Dr.
Santa Fe, New Mexico, 87501

Dear Secretary Ward:

On behalf of the Legislative Finance Committee, I am pleased to transmit the *Adequacy of New Mexico's Healthcare Systems Workforce*. The evaluation assessed workforce adequacy in meeting the demands of the Affordable Care Act when it is implemented in 2014.

An exit conference was conducted with the Department of Health and allied agencies on April 4, 2013 to discuss the contents of this report. We will present the report to the LFC on May 15, 2013.

I believe this report addresses issues the Committee asked us to review and hope all participating entities will benefit from our efforts. We very much appreciate the cooperation and assistance we received from your staff as well as from representatives of other state agencies and associations.

Sincerely,

David Abbey, Director

Cc: Representative Luciano "Lucky" Varela, Chairman, Legislative Finance Committee
Senator John Arthur Smith, Vice-Chairman, Legislative Finance Committee

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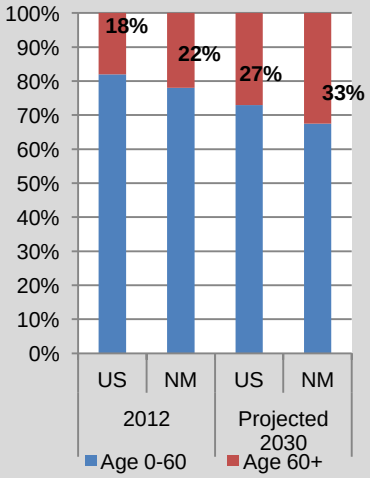
Approximately 415,000 New Mexicans are currently uninsured; more than 98,000 New Mexicans will gain insurance coverage through Medicaid expansion.

Percent of the Population Over 60



Source: NM ALTD

By 2030, New Mexico will rank 4th in the nation for proportion of the population over age 65.

Sixty-two percent of adults in New Mexico were overweight or obese in 2009.

The health system in the United States, including New Mexico, is changing dramatically with the full implementation of the Affordable Care Act (ACA) in 2014 and the corresponding Medicaid and private insurance expansion.

New Mexico's workforce of medical, dental, public health, and behavioral health professionals is fully engaged with the current demand for healthcare services, including providing care to at least some of the state's estimated 415 thousand residents who lack healthcare insurance. Federally Qualified Healthcare Centers (FQHC), Indian Health Services, the Veterans Administration, public health clinics, and hospital emergency rooms have provided care to many of the state's uninsured. In 2014, up to 172 thousand of the state's uninsured population will receive coverage, either through Medicaid expansion or through participation in the health insurance exchange. The newly insured population is expected to include a mix of relatively healthy individuals and chronically ill patients. As with most newly-insured populations, pent up demand will initially drive an early, enhanced pressure for healthcare and related services.

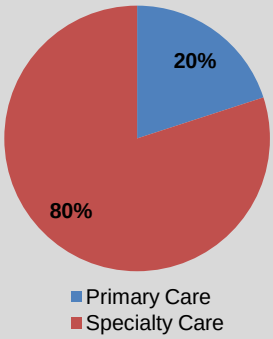
The number of healthcare professionals and their maldistribution throughout the state cannot adequately meet current demand, let alone the additional pressures brought about by the newly insured in 2014. In the near-term, the lack of supply will result in longer wait times to see a provider and more difficulty accessing specialists. As New Mexico's population expands and becomes proportionately older, the state can expect even greater healthcare access problems. Problems will become paramount unless the state employs a more coordinated approach to healthcare service delivery.

This evaluation addresses the adequacy of New Mexico's health system to meet the demands brought about by the implementation of the ACA, exploring current, near-term, and anticipated long-term demand for preventative services and health care and looking at key areas where workforce strategies can be developed to meet demand. Opportunities to address healthcare needs include service delivery systems and patient support structures, recruitment and retention, education and training, and barriers to expanding the workforce, including regulatory and statutory reform.

Healthcare service delivery models that target level of care to patient need are being deployed successfully in the state. About half of the population is basically healthy and can be cared for by NPs and PAs, a professional group that can be trained more quickly and at less cost than physicians. Meanwhile, patients with chronic illness, who consume a disproportionate share of healthcare resources, can benefit from coordinated care using a treatment team of primary care doctors, specialists, case managers, pharmacists, behavioral health specialist and other service providers.

Professionals, such as allied health positions, occupational therapy, physical therapy, radiography, lab technicians, public health workers, emergency

Reported Specialty of 2012 Medical School Graduates



Source: Journal of the American Medical Association

Of the 4,690 doctors actively practicing in the state, only 1,633 (35 percent) list their specialty as primary care.

43.5 percent of New Mexico's practicing physicians report their practice is full and they cannot accept new patients, or they can only accept a few more patients.

medical technicians, are important parts of the healthcare team but were excluded from this report due to time constraints.

Report findings highlight the need for a targeted approach that accounts for the distribution of the population's demand for care and the existing maldistribution of healthcare providers. This evaluation presents opportunities for the Legislature to meet healthcare needs by aligning educational trends to state needs, recruiting and retaining needed professionals, improving the state's regulatory environment, and addressing barriers that prevent the expansion of the workforce.

KEY FINDINGS:

New Mexico's supply of healthcare professionals, particularly in primary care, does not adequately address current needs, let alone those brought about by the ACA and Medicaid expansion, or longer-range demands from population growth and aging. Accurate information about provider supply is limited but improving through the work of the New Mexico Center for Health Care Workforce Analysis at the UNM (UNM), which collects survey data from licensed healthcare professionals.

Despite wide acceptance of a physician shortage, particularly in primary care, the state lacks a strong measure for quantifying shortages. New Mexico has 7,673 licensed medical doctors. However, only 4,690 (61 percent) of these doctors actually practice in the state. The remaining licensees practice in other states, are inactive, or are retired. Of the 4,690 doctors actively practicing in the state, only 1,633 (35 percent) list their specialty as primary care. New Mexico's doctors are not equally distributed across the state with the majority of physicians practicing in the urbanized counties of Bernalillo, Santa Fe, and Dona Ana. When asked about practice plans within the next twelve months, 13.5 percent of New Mexico physicians report that they plan to retire or to significantly reduce their patient care hours.

Applying the Kaiser Foundation ratio of physician population per 100 thousand produces an estimated shortage of 655 doctors. However, most interviewed healthcare professionals seem to place this estimate a bit higher and tend to agree with the UNM Health Sciences Center, which estimates the actual shortage is closer to total 2,000 physicians and roughly 400 to 600 primary care physicians.

Nurse practitioners and physicians assistants could help mitigate the doctor shortage, but their numbers are also inadequate. Nurse practitioners (NPs) and physician assistants (PAs) are growing in importance in the provision of primary care and, in some cases, specialty medicine. New Mexico currently has 970 licensed NPs. Applying the Kaiser Foundation ratio of NPs per 100 thousand population yields a shortage of 236 NPs. The true number is probably much higher. In New Mexico NPs are licensed to practice fully independent of a physician and can perform 70 percent to 80 percent of the procedures performed by a primary care doctor. New Mexico has 577 PAs. PA scope of practice is more limited than that

of NPs because they must have a supervisory physician on their license. However, PAs have the same prescribing authority as NPs and a physician need not be physically present when a PA practices.

New Mexico lacks an accurate and consistent measure for determining provider shortages and needs.

New Mexico has a nursing shortage – as do most other states. No exact benchmarks for how many nurses a population should have exist, but according to the UNM College of Nursing, the state should target the national average, which is 874 nurses per 100 thousand population. Kaiser reports that New Mexico has around 740 RNs per 100 thousand population. Based on the per capita registered nurse (RN) difference between New Mexico and the national average, the target becomes approximately 3,000 additional RNs. Recently the need for additional nurses has been somewhat suppressed by the poor economy, which forces older nurses to continue to work past retirement and tends to make hospitals more conservative in hiring.

HED and DWS data confirm healthcare providers tend to practice near their location of training and are more likely to practice in urban than in rural areas.

New Mexico has too few dentists, and they are maldistributed across the state. Kaiser ranks New Mexico 38th nationally with 1,069 professionally active dentists as of November 2012. Again, this ranking is based on licensure data. It does not accurately reflect those engaged in clinical practice part time versus full time or geographic distribution. According to New Mexico Health Resources (NMHR), a more realistic estimate of practicing dentists in New Mexico is between 700 and 800.

Nine hundred seventy Nurse Practitioners and 577 Physician Assistants are licensed in New Mexico. These advanced practice providers can be trained in roughly one-third of the time and for one-quarter of the cost to train a physician.

The state's supply of dentists suffers from maldistribution. According to information from the New Mexico Regulation and Licensing Department, the vast majority of dentists are concentrated the urban areas of Albuquerque, Santa Fe and Las Cruces. Kaiser Family Foundation estimates that the state needs 155 more dentists to achieve a satisfactory target population-to-practitioner ratio. NMHR places this need closer to 400 more practicing dentists.

New Mexico also experiences a pronounced shortage of clinically-trained behavioral health professionals. To adequately provide for the state's mental health and substance abuse treatment needs, New Mexico needs additional psychiatrists, psychologists and masters-level behavioral health counselors. New Mexico currently has 334 licensed psychiatrists and 705 licensed psychologists. How many are actually practicing and employment location cannot be determined from licensure data.

Sixty-one percent of NPs and 67 percent of PAs are concentrated in Bernalillo, Dona Ana, and Santa Fe counties.

The primary source of behavioral health counseling is provided via masters-prepared counselors. In New Mexico, these are generally licensed social workers and licensed professional counselors.

Over 38 percent of the state's population lives in dental health professional shortage areas.

Little information regarding the ideal numbers of behavioral health professionals needed in the state exists. However, most advocates in mental health and substance abuse would agree that a very pronounced shortage exists. Maldistribution is also a major problem as psychiatrists, psychologists and masters-level counselors are more concentrated in the larger population centers of the state and are much scarcer in rural New Mexico.

Given the growing shortage of healthcare professionals and their

Following healthcare reform, wait times for primary care appointments and some specialty care exceeded 40 days in Massachusetts, despite a larger physician population and a lower newly insured rate. New Mexico should anticipate similar wait time increases following ACA implementation.

distribution across the state, New Mexico should expect some deterioration in access to health care in the near-term. Beginning in 2014, as insurance coverage is expanded, it's unlikely that New Mexico will experience a train wreck. To some degree, most New Mexicans will likely experience the effects of the projected shortfall in the numbers and distribution of the healthcare workforce through reduced access to healthcare professionals and longer wait times to see doctors, dentists, and specialists. Expected decreases in hospital emergency department use will not happen overnight because of gradual insurance uptake rates and the continuing shortage of healthcare professionals. In the long run, as the population increases and gets proportionately older, the state will face critical healthcare workforce supply problems if changes are not made to the way healthcare is delivered.

Healthcare service delivery models must also evolve to adequately address New Mexico's healthcare needs. A new approach is needed to determine where resources can be best deployed to meet the varied healthcare needs of the state's population. Workforce planning, recruitment, and training should then follow this strategy, taking into consideration that not every patient needs the same level of care and that care can be delivered in more efficient and effective ways.

According to the National Ambulatory Survey, one billion physician visits are made in the U.S. annually; 57 percent of these visits are made to primary care physicians.

Not all individuals need the same level of healthcare services. Half of the nation's population is basically healthy. However, patients with chronic health conditions require more specialty care and absorb a greater proportion of healthcare resources. The distribution of the U.S. patient population and corresponding use of healthcare resources is characterized by the Kaiser Family Foundation as follows:

- The top 1 percent of the patient population uses about 22 percent of the healthcare resources, or an average $52 thousand per person per year.

The most frequently reported principal reason for a physician visit is to receive a general medical examination.

- Taken together, the top 50 percent of the population uses 97 percent of the healthcare resources, about $4.5 thousand annually per person. Individuals with stable chronic conditions fall into this group as do some patients over 65 years old, as elderly healthcare needs can increase six-fold.

Five percent of patients consume 50 percent of all healthcare resources, or an average of $17 thousand per person annually.

- The bottom 50 percent of the population is basically healthy and requires only preventative care. The percent of the population that falls into this category consumes only 3 percent of the nation's healthcare resources, roughly $900 per person annually.

A smarter service delivery model will target level of care to level of need. In recent years, an approach that targets resources to the level of patient need has begun to evolve. Patients with multiple chronic illnesses benefit from coordinated care using a treatment team of primary care doctors and specialists working with case managers and other service providers. These teams can return complex patients to more stable, healthy lives and reduce the need for future hospitalizations and specialty care. Correspondingly, relatively healthy patients may be best served through low levels of care and preventative approaches. Fair and realistic payment schemes, ones that

Half of the population is basically healthy and needs little more than occasional care.

Hidalgo Medical Services and First Choice serve as effective community-based models which bring coordinated care to the neediest patients and stress prevention and health promotion.

Known Safety-Net Practitioner Vacancies Reported to New Mexico Health Resources February 2013

Medical Doctors	157
Registered Nurses	11
NPs	46
PAs	18
LISWs	9
Pharmacists	14
Dental Hygienists	6
Dentists	30
Physical Therapists	7
Occupational	2

Source: NMHR

Nationally, the average 2012 medical school graduate holds a debt load of more than $166 thousand.

reward healthcare outcomes rather than the volume of procedures, can be developed to support these models.

In the short-term, if the majority of newly insured New Mexicans are relatively healthy, their needs may be met by increasing the state's supply of NPs and PAs and stressing prevention. New Mexico should shift its emphasis from sick care to wellness and prevention, thus redefining the healthcare workforce and delivery of healthcare services beyond the traditional clinical setting. As the state's population grows and ages, the care-coordination, team model will be the most effective and efficient way to address the needs of patients with chronic diseases. The state's approach to healthcare recruitment and training should reflect this targeted approach.

New Mexico needs to better position itself to recruit and retain an adequate workforce in an increasingly competitive environment. Current healthcare provider recruitment is not able to keep up with demand. New Mexico Health Resources (NMHR) recruits candidates for safety net providers, such as community health centers and critical access hospitals. During the last five years, 255 practitioner placements resulted from NMHR referrals. While statewide provider vacancy rates are unknown, NMHR is currently recruiting for 331 vacant positions.

At the medical school level, recruitment into primary care is a considerable challenge because existing pay systems provide incentives for specialty care practice. The annual income gap between primary care physicians and subspecialty physicians exceeds $135 thousand, and medical students are increasingly selecting subspecialties over primary care. Primary care physicians currently account for 35 percent of practicing medical doctors, but this number is rapidly declining. Twenty percent of all U.S. medical students are now choosing primary care specialties. Yet, 57 percent of all patient visits to doctors are made to primary care physicians.

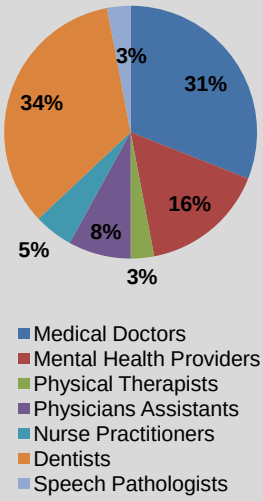
Loan repayment and other financial assistance programs are major incentives to encourage healthcare professionals to work in underserved areas and in primary care. Participation in state and federal programs, including the HED loan-repayment program and the National Health Service Corps, influences practitioner decisions to work in designated medical shortage areas. HED reports funding 48 loan-repayment recipients and 45 loan-for-service recipients in FY13.

Loan-repayment programs seem to provide a better return on investment than scholarship for service programs because practitioners have already selected primary care practice. A 2012 retention study, which included New Mexico, reported substantially more loan-repayment program participants than loan-for-service participants anticipate remaining in their service sites beyond term commitments. Loan-repayment program participants are also less likely to default than loan-for-service recipients.

Pipeline programs help develop a healthcare workforce for underserved

Health Professional Loan Repayment Program Recipients in FY12

total new recipients = 22



Source: HED

Over 70 percent of the state's newly prepared and practicing doctors, pharmacists, PAs, and physical therapists remain in Bernalillo County.

Between 2007 and 2011, New Mexico educated over 4,700 RNs, 263 medical doctors, and 79 physician's assistants.

areas. Research confirms that rural background and specialty preference are associated with physician decisions to work in rural communities. Programs, such as UNM Dream Makers and Forward New Mexico, recruit diverse students into the healthcare pipeline before or during high school. These programs are imperative. The UNM BA/MD program, designed to address the state's physician shortage, admits 28 students each year, and 50 percent of current program participants are minorities. Finally, Hidalgo Medical Service's Forward New Mexico program supports career clubs, enrichment, and academic preparation programs for students in southwestern New Mexico. These pipeline programs will help stimulate interest in health science careers to address shortages in the long-term.

Tort liability laws and tax credits can also serve as incentives for healthcare professionals. Two additional incentives act as tools for recruitment and retention. New Mexico's Medical Malpractice Act limits a provider's personal liability and provides for informal hearings prior to court action. New Mexico's rural tax credit provides a personal income tax credit to healthcare practitioners who provide services in underserved rural areas. During the 2010 tax year, DOH reported that a total of 1,726 recipients took advantage of this tax credit. Almost 50 percent of these were physicians.

Educational strategies may also address the workforce shortage. New Mexico's public and private institutions do an admirable job of educating healthcare professionals but they cannot, by themselves, keep up with growing demand.

Degree production in healthcare professions remained relatively stable between 2007 and 2011, with a few notable exceptions. Between 2007 and 2011, New Mexico educated over 4,700 RNs at various levels. At the same time, New Mexico educated 263 medical doctors and 79 physician's assistants. The state also prepared over 1,000 professionals who may provide behavioral health services, including social workers, substance abuse counselors, and counseling psychologists. The production of RNs declined slightly, while the production of physical therapists, occupational therapists, dental hygienists, and social workers increased during the same period.

New Mexico has not increased the number of nurses educated by the state's public institutions, despite state and national calls for more nurses with bachelor's degrees. In response to the national call for more bachelor-level nurses, New Mexico's colleges of nursing aim to increase the production of BSNs. From FY04 to FY09, $16.5 million in supplemental funding was allocated to New Mexico's public institutions for nursing program enhancement, and $12.2 million was allocated between FY10 and FY13. While the numbers of associate and master-level degrees awarded increased slightly between 2007 and 2011, the number of bachelor degrees produced in-state declined.

Graduate Medical Education residency caps severely limit the numbers of

Between FY10 and FY13, New Mexico allocated $12.2 million in supplemental funding to New Mexico's public institutions for nursing program enhancement and support.

The total number of RN degrees awarded decreased from 1062 in 2007 to 932 in 2011.

Medical residency slots funded by Medicare were capped by the Balanced Budget Act of 1997.

UNMH supports 470 residency slots, most of which are funded through Medicare.

State I&G funds supported 8.1 family medicine residents in FY13.

doctors produced in New Mexico and the United States. To practice medicine, medical school graduates must complete a residency program, also known as graduate medical education (GME). Residencies are primarily supported through Medicare funds, and the total number of funded slots was capped by the Balanced Budget Act of 1997. At the current expansion rate of U.S. medical graduates, the AAMC (AAMC) predicts that the number of graduates from U.S. medical and osteopathic schools will exceed residency slots by the end of the decade, squeezing out applicants from foreign medical schools. International medical graduates make up a disproportionate share of physicians practicing in rural communities.

Nearly five hundred medical residents are working in New Mexico. According to the 2012 National Residency Match Report, 133 new residents matched in New Mexico, and UNM reports that 470 total GME FTE and 120 fellowships were funded in FY13. In 2012, residency programs in New Mexico were located in Albuquerque, Santa Fe, Las Cruces, and Roswell, though Roswell has since lost its accreditation and will not continue to receive residents in the future. In 2008, *House Memorial 2: State Funded Primary Care Residency Slots* recommended increasing the state's 25 family medicine residency slots by 50 percent using recurring general fund appropriations. Since 2008, total family residency slots in New Mexico remain unchanged.

All of the residency slots outside of UNM are devoted to family medicine. Twenty-five doctors began family medicine residency in New Mexico in 2012. While 171 (31 percent) of the residency and fellowship slots at UNM are classified as primary care, many of UNM's primary care residents go on to sub-specialize and ultimately practice specialty care.

The ACA provides new options for GME training which may benefit the state. The ACA created the Teaching Health Center Graduate Medical Education program to support the training of primary care residents and dentists prepared in community-based ambulatory care settings, such as FQHCs. Hidalgo Medical Services, located in southwestern New Mexico, has been approved to become a Teaching Health Center.

Residency programs serve as a major recruitment tool but need to be strengthened in New Mexico. Residency programs help attract and retain practitioners to communities with the greatest medical needs since medical providers tend to establish initial practices near their residency sites. However, UNM's physician survey reveals that only 17 percent attended medical school in New Mexico, suggesting that New Mexico recruits the majority of its physician workforce from out-of-state. Existing medical, nursing, and dental residency programs are insufficient.

Regulatory and practice barriers prevent the full expansion of New Mexico's healthcare workforce. Part of any healthcare workforce strategy should involve an examination of professionals whose roles can be further expanded to extend the impact of the healthcare team. Plans should also identify and reduce barriers to workforce expansion.

The impact of doctors and dentists can be effectively extended through the

Total UNM Residency FTE Funded in FY13, by Specialty

Anesthesiology	31.17
Dermatology	6
Emergency Medicine	33.17
Family Medicine	54.76
General Dentistry	10.60
Internal Medicine	82.13
Neurology	12
Obstetrics/ Gyn.	26
Orthopedic Surgery	25
Pathology	17.7
Pediatrics	46.30
Psychiatry	36.85
Radiology	27.50
Surgery, General	34.50
Neurosurgery	11.66
Ophthalmology	2
Otolaryngology	5.75
Thoracic Surgery	0
Urology	7

Source: UNM HSC

UNM reports 70 percent of dental residents accepted in 2012 are from New Mexico, and 62 percent of dental residents are retained in the state following program completion.

Advanced Care Providers Educated by Public New Mexico Institutions, 2007-2011

MDs	263
NPs	234
PAs	79

Source: HED

expanded use of NPs, PAs and non-dentist practitioners. Part of any healthcare workforce strategy should involve an examination of professions whose roles could be further expanded to extend the impact of the healthcare team. The strategy should also identify barriers to workforce expansion.

New Mexico's limited production of NPs and PAs will inhibit the state's ability to expand its primary care workforce. While medical doctors must complete four years of medical school and a minimum of two years of residency before practicing independently, an NP may be trained in approximately two years after earning a BSN, and a PA requires roughly two years of graduate-level training. NCSL estimates that NPs can be trained at 20 to 25 percent of the cost to train a physician, while a previous LFC evaluation of the UNM HSC estimated the cost to educate a physician exceeds $500 thousand. The UNM College of Nursing estimates educating a BSN-level nurse to the NP level costs roughly $64 thousand. The state's public institutions educated 234 NPs and 79 PAs between 2007 and 2011, while the state's medical school educated 263 physicians during the same period of time.

The state needs to address barriers that prevent the expansion of NP training programs. Despite lower educational costs, the state's production of physicians continues to surpass that of NPs. Colleges of Nursing cite several significant barriers that prevent program expansion. Qualified nursing faculty serve as a barrier to expanding the nursing workforce. Colleges of nursing also report that the discrepancy between nursing faculty salaries and clinical nursing salaries is a significant barrier to attracting qualified faculty. Colleges also cite a limited BSN pool, inadequate clinical placement sites, and credentialing inefficiencies as barriers to expanding the state's NP workforce.

Modifying regulatory statutes that govern other advanced practice providers, including physician assistants and prescribing psychologists, may help eliminate barriers to full practice. PAs may examine, prescribe, and treat patients, and may effectively provide common primary care services but must work under the license and supervision of a physician. Requiring supervision of PA practice may restrict their ability to deliver primary care. Modifying supervision requirements for LISW and prescribing psychologists would facilitate the expansion of the state's behavioral health workforce.

KEY RECOMMENDATIONS:

The Legislature should:

Consider passing legislation to expand state-funded family medicine residencies. To accomplish this objective, the Legislature should appoint a panel of industry experts to study realistic strategies including revisiting the recommendations made in the 2008 Health Policy Commission report on state-funded family medicine residency slots. The study group should make recommendations to the Legislature no later than November 2013.

Expand WICHE funding, expand state-funded rural residencies, create

NCSL estimates the cost to educate an NP is 20 percent to 25 percent of the cost to educate a physician.

Advanced Primary Care Training at UNM

	Length of Training	Credit Hours	Tuition Cost
MDs	6+ years	4 years	$65,000
NPs	2 years	54-56	$31,000
PAs	27	86	$32,000

Source: UNM

Both NMSU and UNM have moved toward replacing master's-level nursing programs with doctoral-level programs, increasing nursing faculty supply but reducing the supply of NPs and advanced practice nurses available to provide direct services.

In New Mexico, the PA scope of practice is more limited than that of NPs.

training programs for dental auxiliaries, and revisit the concept of dental therapists.

Increase appropriations to loan repayment programs as opposed to loan for service programs, which tend to have lower rates of retention.

Work with UNM Health Sciences Center to ensure adequate base funding for the New Mexico Center for Health Workforce Analysis at UNM.

Ensure the Department of Health has adequate resources to carry out its statutory responsibility to conduct workforce planning. The Department of Health should collaborate with the New Mexico Center for Healthcare Workforce Analysis at UNM.

A single agency, such as New Mexico Health Resources, should coordinate all healthcare workforce recruitment for both the public and private sectors in New Mexico.

New Mexico's public universities should not require all NPs to earn a doctorate degree since this may restrict the number of NPs providing direct care. Universities should maintain master's-level clinical nurse training programs.

New Mexico's public universities should report on the feasibility of creating additional master's-level clinical nursing programs.

The Medical Board should revisit the scope of practice for PAs to allow these professionals the same degree of independence that NPs are allowed in the state. PAs should be allowed this independent practice status after completing three to five years of clinical supervision by a physician.

New Mexico's Behavioral Health Licensing Boards should expand the mental health masters degrees that qualify for supervision and licensure, streamlining the requirements for mental health counselor reciprocity with other states, and expanding the capacity for clinical licensure supervision, including the use of teleconferencing to provide supervision to remote sites.
New Mexico's healthcare licensing boards should conduct a comprehensive review of all healthcare professional practice acts to judiciously reduce barriers to workforce expansion.

BACKGROUND

The two principal forces that will expand healthcare coverage are the Affordable Care Act (ACA) and the Medicaid expansion program in New Mexico.

The Affordable Care Act The ACA of 2010, formally titled the Patient Protection and Affordable Care Act, is intended to expand healthcare insurance coverage, to improve healthcare delivery and control costs. The law includes the following key provisions:

1. Requires U.S. citizens and legal residents to have health insurance or pay a penalty
2. Creates state-based health insurance exchanges through which individuals can purchase coverage, with premium and cost-sharing credits available to individuals/families with income between 133 percent to 400 percent of the federal poverty level;
3. Creates separate insurance exchanges through which small businesses can purchase coverage;
4. Requires employers to pay penalties for employees who receive tax credits for health insurance through an exchange, with exceptions for small employers;
5. Imposes new regulations on health plans in the insurance exchanges and in the individual and small group markets ;
6. Expands Medicaid to 133 percent of the federal poverty level;
7. Requires states to maintain current income eligibility levels for children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019 and then extend funding for CHIP through 2015; and
8. Provides premium and cost-sharing subsidies to eligible individuals in the exchanges.

Major provisions of the Patient Protection and Affordable Care Act (ACA), including mandatory health insurance, healthcare insurance exchanges and state-optional Medicaid expansion, go into effect on January 1, 2014.

Insurance Exchange New Mexico is creating and operating its version of the mandatory health benefit exchange, through which individuals can purchase coverage. Premium and cost-sharing credits are available to those with incomes between 133 percent and 400 percent of the federal poverty level. The 2013 federal poverty level is $19,530 for a family of three.

Table 1. 2013 Federal Poverty Level

Household Size	100%	133%	150%	200%	300%	400%
1	$11,490	$15,282	$17,235	$22,980	$34,470	$45,960
2	$15,510	$ 20,628	$23,265	$31,020	$46,530	$62,040
3	$19,530	$ 25,975	$29,295	$39,060	$58,590	$78,120
4	$23,550	$ 31,322	$35,325	$47,100	$70,650	$94,200
5	$27,570	$ 36,668	$41,355	$55,140	$82,710	$110,280
6	$31,590	$ 42,015	$47,385	$63,180	$94,770	$126,360
7	$35,610	$ 47,361	$53,415	$71,220	$106,830	$142,440
8	$39,630	$ 52,708	$59,445	$79,260	$118,890	$158,520
For each additional person, add	$4,020	$5,347	$6,030	$8,040	$12,060	$16,080

Source: Families USA

The individual mandate provision of the ACA requires U.S citizens and legal residents to have qualifying health coverage or pay a tax penalty. By 2016, this penalty becomes the greater of $695 per year or 2.5 percent of income. The penalty will be phased-in according to the following schedule: $95 in 2014, $325 in 2015, and $695 in 2016. After 2016, the penalty increases annually by the cost-of-living adjustment.

While the ACA expanded insurance coverage to an additional 48.6 million people nationally, universal coverage does not equal universal access (U.S. Census Bureau). There are exemptions from this penalty available for identified groups, such as Native Americans. Depending upon the insurance premiums available in the exchange, some individuals will likely chose the penalty over insurance coverage.

Additionally, estimating the exact size and make-up of New Mexico's uninsured population remains difficult. Uncertainty and disagreement surround estimates of the state's uninsured population, which range from 400 thousand to 430 thousand, though several groups have attempted to measure and describe this group. The Human Services Department (HSD) reports that in New Mexico, 35 percent of Native Americans, 22 percent of Hispanics, and 13 percent of non-Hispanic whites are uninsured. In 2012, the Hilltop Institute used 2009 U.S. Census data to project the 2012 uninsured population and reported that the largest proportion of the state's uninsured are poor adults. The U.S. Census Bureau estimates approximately 20 percent of the uninsured population comprises undocumented immigrants. In 2008, Pew Research Hispanic Institute study estimated between75 thousand and 85 thousand undocumented immigrants lived in New Mexico.

Table 2. Percent of Uninsured by Federal Poverty Level (FPL), 2009

Total Estimated Uninsured= 428,249
FPL= $23,050 annual income for family of four

Age Group	Below 100% FPL	100%-199% FPL	200%-299% FPL	300%-399% FPL	400%+ FPL	Total
0 to 17	9%	3%	2%	1%	0.7%	**15.7%**
18-64	26%	22%	15%	7%	12%	**82%**
65+	0.6%	0.6%	0.2%	0.2%	0.4%	**2%**
Total	**35.6%**	**25.6%**	**17.2%**	**8.2%**	**13.1%**	

Source: Hilltop Institute

Quantifying demand increases remains difficult as uncertainty about the demographics of the uninsured population and how their healthcare decisions will change with the implementation of the ACA are unknown. Determining how many New Mexicans will enroll in the health insurance exchange is difficult. HSD uses a range of enrollment estimates derived from three sources:

Table 3. Projected Enrollment in the New Mexico Health Insurance Exchange

	2014	2015	2016	2017	2018	2019	2020
Hilltop Institute	52,055	96,718	106,958	118,397	127,549	134,796	141,930
Congressional Budget Office	63,020	101,331	167,361	182,893	191,240	192,287	185,913
Leavitt Partners	73,876	102,605	128,637	153,389	173,855	172,779	177,574

Source: NMHSD -- January 17, 2013

Medicaid Expansion New Mexico adopted the ACA provision that allows states to expand Medicaid eligibility to 138 percent of the federal poverty level (FPL). Medicaid currently provides healthcare coverage to approximately 560 thousand New Mexicans, mostly dependent children. The expanded program will extend eligibility to another 170 thousand individuals. The New Mexico Human Services Department (HSD) estimates that about 137 thousand new individuals will actually enroll in Medicaid. This number will grow to 167 thousand by FY20.

Table 4. Estimated Medicaid Enrollment under ACA (up to 138 percent FPL)

	FY14	FY15	FY16	FY17	FY18	FY19	FY20
Baseline	554,274	574,773	588,787	602,402	616,304	630,503	645,002
Woodwork*	14,089	15,677	17,292	18,910	20,587	22,265	22,538
Expansion **	123,019	136,081	149,075	150,067	146,979	147,775	144,492
Total	691,382	726,531	755,154	771,379	783,870	800,543	812,033
Net ACA Change	**137,108**	**151,758**	**166,367**	**168,977**	**167,566**	**170,040**	**167,030**

Source: NMHSD -- January 17, 2013

*Enrollment by those who are already eligible but enroll primarily because of the mandate
**Includes those formerly covered by State Coverage Insurance Program.

According to the HSD, 39 thousand individuals are currently enrolled in State Coverage Insurance (SCI) and are included in the newly eligible for Medicaid estimate, leaving 98 thousand New Mexicans newly covered by health insurance.

The effect of healthcare insurance coverage under the ACA and Medicaid expansion is expected to increase the demand for healthcare services in New Mexico in 2014, with gradual expansion in outgoing years.

DEMAND FOR HEALTHCARE IS DRIVEN IN THE NEAR-TERM BY EXPANSION OF THE INSURED POPULATION AND IN THE LONGER TERM BY POPULATION GROWTH AND AGING

New Mexico's newly insured population will be unevenly distributed and demand more care. With the implementation of the ACA in 2014, New Mexico's previously uninsured population will fall into three general categories. When New Mexico's insurance exchange and the Medicaid expansion are implemented in 2014, currently uninsured New Mexicans will include: those newly eligible for Medicaid, those projected to participate in the insurance exchange, and those who will remain uninsured either because they choose not to participate in the insurance exchange or because they are undocumented immigrants. Additional detail about these groups may be found in **Appendix J.**

Table 5. New Mexico's Previously Uninsured Population Following ACA Implementation

Newly Eligible Medicaid (~170,000 eligible, including the 39,000 currently enrolled in SCI)*	Exchange Participants (~189,000 eligible for subsidies)	Remaining Uninsured
Projected enrollment (HSD): 137,000 in 2014 167,000 by 2020	Projected enrollment: 52,000 to 75,000 in 2014 144,000 to 177,000 in 2020	Urban Institute Projection:~ 240,000 (12% of the population)
Predicted Demographics	**Predicted Demographics**	**Predicted Demographics**
Mix of healthy and chronically ill adults Initial enrollees will have the most significant healthcare needs Poorest individuals will be the most likely to enroll and have the highest levels of morbidity and chronic disease, as compared to adults with incomes closer to 138% of the FPL	Enrollees will be relatively older, less educated, have lower incomes, and be more racially diverse than individuals privately insured prior to the ACA Adults between the ages of 19 and 64 will account for 64 percent of enrollees, and the average age of enrollees with be approximately 35 52 percent of enrollees will be male and 48 percent will be female Likely enrollees report being in worse health but having fewer diagnosed chronic conditions than individuals privately insured prior to the ACA	This group will be composed of undocumented immigrants and individuals who elect not to obtain coverage This group is predicted to be of greater income and better health than the population predicted to enroll in the Exchange. However, individuals who elect not to purchase insurance are predicted to be of lower income than people projected to enroll in the private insurance market

Source: LFC analysis

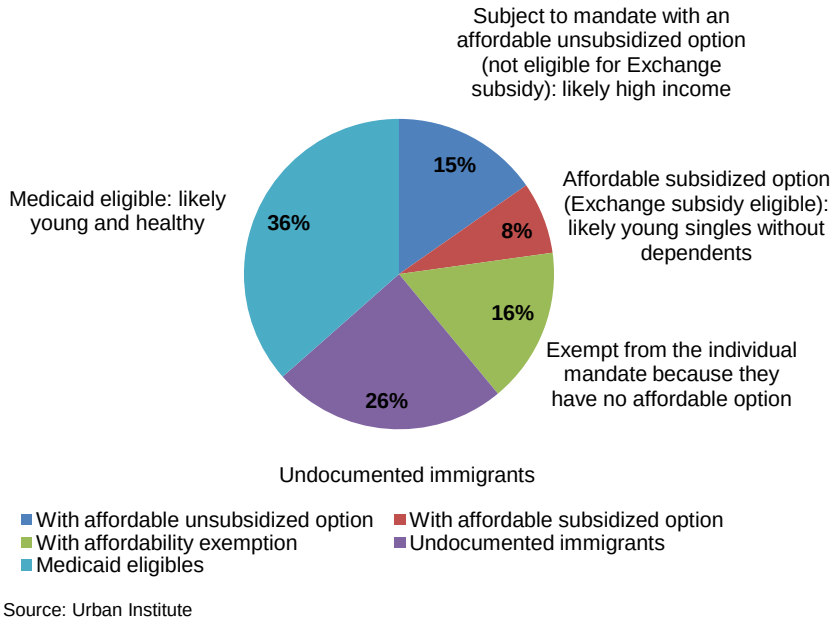
*The projected Medicaid enrollment of 137 thousand in 2014 includes 39 thousand individuals currently enrolled in State Coverage Insurance, who will be transferred to Medicaid.

New Mexico's uninsured population is not evenly distributed. According to the U.S. Small Area Health Insurance Estimates of 2010, the counties with the largest uninsured population are Bernalillo (116,535), Dona Ana (46,450) and San Juan (33,447), while McKinley, Catron, and Harding counties have the highest uninsured rates in the state. Luna, Dona Ana, and Hidalgo counties have the highest rates of uninsured adults who are predicted to qualify for Medicaid under the approved expansion (**Appendix L**)**.** Newly insured patients are expected to seek services in their communities, and counties should expect varying levels of new demand for services in 2014.

Despite the ACA individual mandate, the state should not expect all New Mexicans will obtain insurance. Medicaid has always experienced under-enrollment, and individuals who do not qualify for Medicaid may elect to pay the penalty for not obtaining insurance rather than to purchase coverage. Kaiser estimates one-third of the

currently eligible Medicaid population remains uninsured. Massachusetts reported that 3.4 percent of the state's population remained uninsured five years after implementing healthcare reform and began with a considerably lower uninsured rate (9.6 percent) than New Mexico now experiences (21 percent).

Chart 1. Distribution of Nonelderly Uninsured Adults Under the ACA
n= 19 million Americans



Source: Urban Institute

The Hilltop Institute predicts Medicaid take-up rates will vary among the state's population and range between 52 percent and 62 percent. Take-up among Native Americans, exempt from the ACA mandate, is expected to be only 20 percent. However, additional New Mexicans who are currently eligible are expected to enroll in Medicaid as a result of the ACA. This enrollment is categorized as the "woodwork effect." By FY19, HSD forecasts 800 thousand eligible New Mexicans will enroll in Medicaid, including a base of 630 thousand enrollees, 22 thousand individuals who enroll because of the "woodwork effect," and 148 thousand individuals who will enroll as a result of Medicaid expansion.

Resource utilization by newly-insured individuals will likely be influenced by pent-up demand. Rather than being simply a change in the source of payment for healthcare, the ACA will produce an increase in the level of care received by New Mexicans who are currently without insurance coverage. Insured and uninsured patients utilize healthcare differently, as the uninsured often choose not to seek elective or primary care. Insured patients tend to make a quarter to two and a half more primary care visits per year than uninsured patients, suggesting that the state should assume that newly insured patients will seek previously deferred care. Research also suggests that pent-up demand for physician care exists among aging patients, as new Medicare beneficiaries make 30 percent more physician visits during the two years following enrollment (Chen et. al 2004).

The HSD reports pent-up demand when newly-insured clients begin receiving State Coverage Insurance (SCI) or enroll in the coordination of long-term services (CoLTS) program. Thus, while quantifying the behavior of newly insured patients may remain difficult, New Mexico should assume pent-up demand will influence the volume of services sought by patients gaining insurance coverage.

Estimating if and where New Mexico's uninsured are currently receiving health care remains difficult. Some of the uninsured are receiving care from government or tribal programs, while others appear to be using New Mexico's healthcare safety net. The implementation of the ACA will bring about a change in the way that many New Mexican's receive healthcare. Currently, many of the estimated 400 thousand-plus uninsured New Mexicans are receiving primary care services through the state's system of rural health clinics, federally qualified health centers (FQHC), Indian Health Service (IHS), the Veteran's Administration (VA) and, to some degree, hospital emergency rooms. An unspecified number of the uninsured receive no health care – either because they are young and relatively healthy or for some other reason.

In 2011, New Mexico's FQHCs provided primary care services to 111,181 uninsured patients. The uninsured population represented 39 percent of the total patient census that year. These uninsured patients were distributed across the state as follows:

Table 6. Distribution of Uninsured FQHC Patients in New Mexico

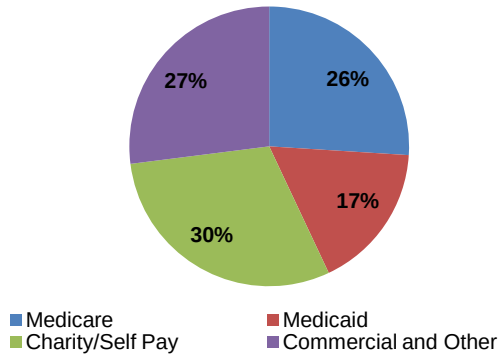
Central	Southwest	Southeast	Northeast	North Central	Northwest
35,888	28,853	15,287	1,791	22,128	7,234

Source: New Mexico Primary Care Association

Though most healthcare professions agree that emergency departments (ED) serve as default sources of primary care among uninsured patients, trying to determine the exact degree of ED use by the uninsured is difficult. The Center for Disease Control and Prevention reports that uninsured adults are more likely than insured adults to report visiting the ER because they have no other place to receive care. The Pew Center on the States 2010 report revealed that 800 thousand Americans per year use the ED for dental emergencies annually.

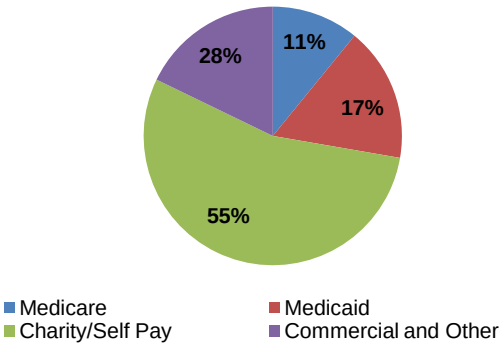
The UNMH reported 25,678 ED visits during the last half of 2012. Seventy-nine percent of these patients were discharged home, rather than being admitted to the hospital. Of these, 17 percent were Medicaid recipients, and 55 percent were considered self-pay or charity care.

Chart 2. Patients Admitted to UNMH from the Emergency Department



Source: UNMH

Chart 3. Patients Discharged Home from the UNMH Emergency Department



Source: UNMH

The ACA intends to reduce the use of urgent care and emergency rooms for non-emergent conditions. With Medicaid expansion and increased coverage under the ACA, patients should have more choices, and providers who previously absorbed the cost of uncompensated care will begin to see some level of reimbursement. However, as primary care providers will not likely be able to meet demand in the short-term, the newly insured will likely continue to use EDs as their principal source of care initially.

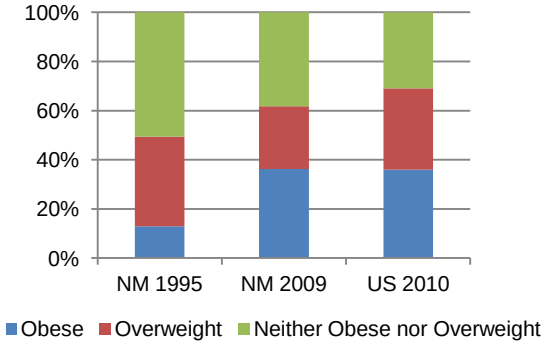
New Mexico's Department of Health (DOH) emphasizes population-based public health services and research. However, when necessary, the Public Health Division provides direct services delivered in a one-to-one clinical setting. These direct services are provided where the existing healthcare workforce cannot meet a particular need. For example, DOH provides prenatal care in the southeast region of the state. The Public Health Division does not purport to be a fully-integrated primary care system, nor do they want to be. Where service gaps exist, DOH can provide direct services to individuals, including the uninsured. DOH will take on a greater role in assuring that the evolving health care system is responsive to the ACA.

Indian Health Services (IHS) and Veterans Affairs (VA) also provide services for qualifying patients. See **Appendix J.**

Demand will be shaped, in part, by the specific demographics of New Mexico. Access to care in New Mexico is limited. Thirty-two of New Mexico's 33 counties are designated as health professional shortage areas (HPSA). According to the U.S. Health Resources and Services Administration (HRSA), a primary care HPSA is based on a ratio of one primary care physician to 3.5 thousand population, a dental HPSA is based on a ratio of 1 dentist to 5 thousand population and a mental health HPSA is based on one psychiatrist to 30 thousand population. As the insured population grows, epidemiological trends in New Mexico suggest further stress on demand for medical and mental health resources in the state. The following trends will only further increase demand for care in the state as the state ages and rates of chronic conditions rise:

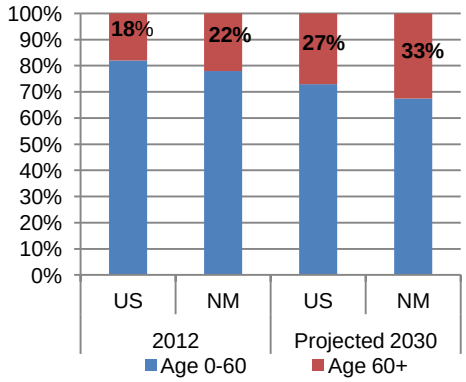
- By 2030, New Mexico's Aging and Long Term Services Department projects the state will rise from 39th to 4th in the nation with respect to the proportion of the population that is age 65 or older;
- The U.S. Administration of Aging predicts 33 percent of the state's population will be age 60 or older by 2030;
- Sixty-two percent of adults in New Mexico were overweight or obese in 2009;
- Morbid obesity (defined as 100 pounds or more overweight) doubled in New Mexico during the last decade; and
- Twenty-one percent of New Mexico third graders are obese.

Chart 4. Increase in Obesity Prevalence



Source: DOH

Chart 5. Percent of the Population Over 60



Source: NM ALTD

Because behavioral health concerns are prevalent in New Mexico, expansion of insurance coverage will likely increase the population's demand for mental health services. States that have expanded public insurance coverage, including Oregon, report the utilization of mental health services among newly covered childless adults is significantly greater than that of previously eligible adults.

- Over the last 15 years, the death rate for alcohol-related chronic diseases, such as cirrhosis of the liver, has increased to almost twice the national average, and New Mexico is ranked first in the nation in alcohol-related mortality;

- Injury death rates attributable to alcohol abuse are almost twice the national rate;
- Overdose death rates from illicit drugs and prescription drugs (particularly opioids) have increased 150 percent in the past five years and according to DOH, the state is second in the nation in substance abuse overdoses;
- In 2011, 29.1 percent of New Mexico high school students felt persistent sadness or hopelessness;
- Behavioral health surveys estimate 9.1 percent of the state's adult population suffers from depression.

Regional health disparities also shape demand. DOH notes that health status can vary according to a number of factors, including geographic location. Pronounced disparities are apparent among the five major health regions. For example, Chaves, Curry, De Baca, Eddy, Harding, Lea, Quay and Roosevelt counties, tend to have the worst health status, with high rates of diabetes, asthma, heart disease, cancer, chronic lower respiratory disease, and cerebrovascular disease.

Table 7. Leading Causes of Death by Region, NM, 2011
Deaths per 100,000 per year

	NW	NE	Metro	SW	SE
Heart Disease	143.9	120.2	145.8	147.8	185.5
Cancer	144.0	130.9	139.5	146.1	157.2
Unintentional Injury	83.1	75.8	59.7	47.8	60.9
Chronic Lower Respiratory Disease	45.2	36.0	42.8	45.9	66.1
Cerebrovascular Disease	21.1	27.4	37.3	32.8	32.3
Diabetes Mellitus	38.5	28.4	25.0	22.2	25.8
Drug Overdose	14.9	34.7	28.5	23.7	20.4
All Causes	800.3	678.9	721.4	720.9	825.8

Source: New Mexico Death Certificate Database, Office of Vital Records and Statistics of Health Indicator-Based Information

Pockets of disparity exist throughout the state. For example, immigrants tend to have lower levels of drug overdose, lower alcohol-related mortality, less chronic disease, and lower suicide rates. Native Americans tend to have high rates of injury deaths, alcohol-related problems, and suicide. A thorough analysis of New Mexico's health status, and the demand for healthcare services, needs to take into consideration these sub-state factors. Notably, regional health disparities that drive healthcare demand are not always in sync with the distribution of healthcare resources in the state, as will be discussed later in this report.

NEW MEXICO'S SUPPLY OF HEALTHCARE PROFESSIONALS, PARTICULARLY IN PRIMARY CARE, DOES NOT ADEQUATELY ADDRESS CURRENT NEEDS, LET ALONE THOSE BROUGHT ABOUT BY THE ACA AND MEDICAID EXPANSION

Accurate information regarding New Mexico's current and projected supply of healthcare workers remains vague. The state has no mechanism for accurately collecting information on the number of professionals practicing in New Mexico. For example, information on physicians practicing in rural areas is only available from the rural healthcare practitioner tax credit program. Most information regarding healthcare practitioner distribution is gathered from licensure data. As practice addresses have not been verified, determining if a person is licensed but not practicing, or is practicing in multiple locations, in different counties, or in another state is impossible. The number of hours an individual works, or provides direct care, is also unavailable via licensure data.

Data availability is improving with the transfer of health professional licensure and survey data from DOH to the UNM Health Sciences Center (UNMHSC). As a condition of New Mexico licensure, healthcare professionals are now required to complete a survey providing, among other things, more specific information regarding hours and locations of practice. The first year of this data is presently being analyzed by the New Mexico Center for Health Workforce Analysis at UNMHSC. The entire study should be available later this year. Physician survey information for 2011 through 2012 is now available.

Despite wide acceptance of a physician shortage, particularly in primary care, the state lacks a strong measure for quantifying shortages. According the UNM Workforce Analysis Center 7,673 medical doctors are licensed in New Mexico. However, only 4,690 (61 percent) of these doctors practice in the state. The remaining licensees practice in other states, are inactive, or are retired.

Of the 4,690 doctors actively practicing in the state, only 1,633 (35 percent) list their specialty as primary care. New Mexico's primary care doctors spend about 83 percent of their time providing direct patient care, and 70 percent of their practices are in outpatient or clinic settings. The survey data does not reveal the numbers of New Mexico doctors who practice part time. A number of physicians have likely cut back practice hours in anticipation of retirement.

The nation lacks standardized benchmarks for determining the ideal size of a physician population. For example, a 2009 estimate by Dr. Daniel Derksen, former director of the New Mexico Office of Health Care Reform, used two standards patient panel to primary care physician ratios: 1,250 patients and 1,500 patients. Based on a 1,250 patient standard, the report determined that the state is short 380 primary care physicians, while a 1,500 patient standard indicates the state is short 112 primary care physicians.

A standard of physicians per 100 thousand population is also commonly cited but is misleading. According to the Kaiser Foundation, in 2008, the national average ratio was 257 physicians per 100 thousand population. Applying this standard in New Mexico translates to 5,355 doctors, suggesting a shortage of 655 doctors. However, as the Health Policy Commission pointed out in a 2006 report, using ratios alone to project long-term needs or shortages fails to account for population aging or usage rates. According to a UNMHSC report to the HHS, New Mexico has a current shortage of approximately two thousand physicians. The same report places the state's primary care physician shortage between 400 and 600 doctors.

The AAMC reports a national shortage of more than 13 thousand physicians and predicts that this shortage will continue to expand. The AAMC believes that within 5 years the nation will experience a deficit of 62,900 physicians. This shortage is expected to double by 2025.

Table 8. National Projections for Full-Time Physicians Active in Patient Care

Year	Physician Supply (All Specialties)	Physician Demand (All Specialties)	Physician Shortage (All Specialties*)	Physician Shortage (Non-Primary Care Specialties)
2008	699,100	706,500	7,400	**None**
2010	709,700	723,400	13,700	4,700
2015	735,600	798,500	62,900	33,100
2020	759,800	851,300	91,500	46,100
2025	785,400	916,000	130,600	64,800

Source: AAMC Center for Workforce Studies

A 2012 report in the *Annals of Family Medicine* used census data to predict how many doctors will be needed as the population grows, ages, and gains access to insurance and what proportion of the need increase may be attributed to each of these drivers. The main driver of provider demand is population growth, accounting for 63 percent of the need, followed by the aging of the population, accounting for 19 percent of the need. Lastly, 15 percent of the need for new primary care physicians is driven by expansion of the newly insured.

UNM survey data reveal that 43.5 percent of New Mexico physicians report that their practice is full or they can only accept a few more patients. The traditional image of the solo, private practice physician is disappearing. Sixty-four percent of New Mexico physicians practice in groups of three to ten or more physicians. About one-third of physicians work in independent practice; the remainder work for hospitals, clinics, agencies, government facilities, or corporate practices.

New Mexico experiences shortages among other key healthcare practitioners. Nurses, PAs, therapists, behavioral health providers, and dentists provide essential services but are also in short supply.

New Mexico has successfully integrated NPs into the healthcare workforce because of the state's expansive practice act. A NP is an RN with an advanced graduate education, including extensive clinical training in medicine. NPs must have a master's or doctorate-level degree to be licensed. Approximately 970 NPs are licensed in the state, according to the New Mexico Board of Nursing. The Kaiser Foundation (2011) cites the national average as 58 NPs per 100 thousand population. If New Mexico applies the national average to its population, the state requires 1,206 NPs. To reach the national average, New Mexico will need approximately 236 more NPs. UNM surveyed provider organizations about their current need for NPs and received 110 reports from providers requesting NPs. Presbyterian Health Care alone reported a need for 60 additional NPs.

New Mexico has 577 licensed PAs. Nationally, New Mexico ranks 31st in the nation with 29 PAs per 100 thousand population. However, this ratio is still above the national average of 27 PAs per 100 thousand. Although PAs can be an effective workforce extender in primary care, particularly in rural areas, currently they tend to work in hospitals with physicians, often as part of a surgical team.

Despite the fact that more RNs are practicing in the United States than at any other point in history, New Mexico has a nursing shortage – as do most other states. Though no benchmark for ideal nursing supply size exists, the UNM College of Nursing suggests the state should aim for the national average, 874 nurses per 100 thousand population. Based on 2011 data, New Mexico ranks 44th in the nation with 740 RNs per 100 thousand population and requires 3 thousand additional nurses.

The New Mexico Center for Nursing Excellence reports the current number of licensed nurses with New Mexico residency as 19,402. The Center also reports a current employment rate of New Mexico nurses of 80.5 percent, approximately 15.6 thousand nurses in the workforce. The Center's director, Pat Boyle, indicates that there is very little information on the demand for nurses from employers. Estimates of nursing demand generally take into consideration retirement rates, new demand driven by the Affordable Care Act, and population growth. In 2009, the House Joint Memorial 40 taskforce reported that New Mexico will face an estimated shortage of 5 thousand nurses by the year 2020.

Estimates of the national nursing shortage range from 300,000 to 1 million RNs by 2020. In a 2012 study published in *Public Health Resources*, researchers used projected changes in population and age to develop demand and supply models to forecast the nursing shortage in all 50 states. The model projected a severe shortage throughout the county by 2030, with the western region (including New Mexico) having the largest shortage.

Kaiser ranks New Mexico 38th nationally with 1,069 professionally active dentists as of November 2012 (see **Appendix F**). However, this ranking is based on licensure data and does not accurately reflect dentists engaged in full-time clinical practice. According to Jerry Harrison of NMHR, a more realistic estimate of practicing dentists in New Mexico is between 700 and 800. Kaiser reports that in 2012 over 38 percent of New Mexico's population lived in a dental health professional shortage area, and 25 percent of the state's population (over half a million people) remains underserved. Kaiser estimates an additional 155 dentists are needed to achieve a satisfactory population-to-practitioner ratio. New Mexico Healthcare Resources places this need closer to 400 more practicing dentists.

Additionally, the Dental Board reports 997 dental hygienists licensed in the state, though the number of hygienists in practice is unknown (see **Appendix F**). In 2012, 44 percent of the state's hygienists reported licensure addresses in Bernalillo County; 9 percent listed Dona Ana County, and 12 percent listed Santa Fe County.

New Mexico has 1,700 Registered Pharmacists. The UNM College of Pharmacy produces about 86 pharmacists per year, and 85 percent to 90 percent of these graduates are from New Mexico. The College estimates that 62 percent of all pharmacists practicing in New Mexico are UNM alumni.

Nationally, the pharmacist workforce is experiencing growth; the number of pharmacy schools recently expanded from 80 to 129 nationally and is still growing, according to UNM. National estimates place the number of required pharmacists at 30,000 by 2020 – largely driven by the ACA. Determining the need for pharmacists in New Mexico is more difficult, since the actual numbers of practicing pharmacists and practice locations have not been determined with any precision. However, more accurate information is anticipated with the full implementation of licensing surveys in the state.

Currently, New Mexico has 334 psychiatrists, representing 14 percent of all medical specialists. Though evidence regarding the adequacy of New Mexico's supply of psychiatrists is largely anecdotal, appointment wait times reported by UNM's Center for Behavioral Health Training and Research suggest the existing supply is woefully inadequate. Shortages tend to be more pronounced in rural areas and are felt at the national level as well; the Department of Veterans Affairs reports a 20 percent psychiatrist vacancy rate in its VA hospitals.

Behavioral health services are primarily provided by master's-prepared counselors and social workers. The New Mexico Social Work Board is responsible for overseeing the licensing of social workers with varying levels of education. At the highest level, LISWs undergo considerable supervised clinical training, are able to operate under their own license, and bill independently. LMSWs have passed a licensing test and are eligible for additional training under an LISW to achieve independent status but cannot bill independently. The New Mexico Social Work Board reports that 1,668 LISWs are currently licensed in the state.

The state's other major group of behavioral health professionals is licensed through the New Mexico Counseling and Therapy Practice Board. Counseling preparation ranges from certificate programs directed at treating substance abuse problems, to fully independent master's-level counselors. A total of 4,354 behavioral health professionals are currently licensed by this board.

The New Mexico Psychological Board reports that 705 licensed psychologists are currently licensed in the state. In New Mexico, this doctoral-level professional group tends to engage in psychological testing and sophisticated diagnostic work.

New Mexico is one of only a few states that provides for the licensing of psychologists who are allowed limited prescribing privileges under consultation with a primary care physician. Preparation essentially involves an American Psychological Association accredited, post-doctoral master's program with strict training and supervisory requirements. Legislation enabled the prescribing psychologist practice in 2002, largely in response to the state's psychiatrist shortage. Presently, 39 prescribing psychologists are licensed in New Mexico.

Table 9. Mental Health Providers Licensed in 2013

Counseling Board	
Licensed Alcohol and Drug Abuse Counselors	650
Licensed Professional Clinical Counselors	1875
Licensed Mental Health Counselors	832
Licensed Marriage and Family Therapists	314
Licensed Professional Counselors	357
Licensed Substance Abuse Associate	326
Psychological Board	
Psychologists	705
Prescribing Psychologists	39
Social Work Board	
Licensed Bachelor's Social Workers	650
Licensed Master's Social Workers	1,296
Licensed Independent Social Workers	1,668

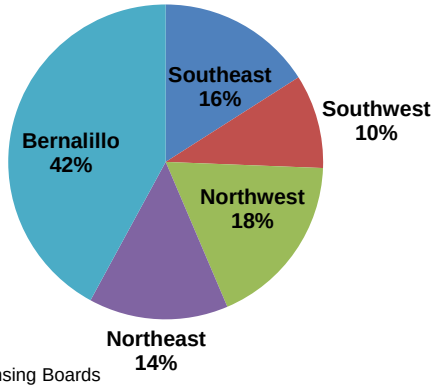
Source: New Mexico Regulation and Licensing Department

Little information regarding the ideal numbers of mental health counselors needed in the state exists. However, most advocates in mental health and substance abuse agree a pronounced shortage of effective, trained counselors exists. Unfortunately, the number of substance abuse counselors is also declining. According to the *2012 New Mexico Substance Abuse Prevention and Treatment Block Grant – Independent Peer Review Committee Annual Report*, the pool of licensed professional applicants to substance abuse treatment agencies continues to shrink. A declining provider pool may result in "possible deficiencies during auditing and accreditation visits." While the committee is not certain about the cause of this decline, low salary, lack of third party payee/resources, lack of license reciprocity, and non-competitive salaries for potential candidates may be contributing factors. The cost of training and licensure in the field of substance abuse may also be a disincentive, reported the committee.

Maldistribution is also a significant problem among New Mexico's healthcare workforce. Approximately half of New Mexico's population is concentrated in three counties with urban areas: Bernalillo (32 percent), Dona Ana (7 percent) and Santa Fe (10 percent). Yet survey and licensure data reveal that a disproportionate majority of the state's healthcare workforce is concentrated in the counties where many of the state's major medical centers are located.

DOH's Public Health Division points to regional disparities in the distribution of healthcare resources in New Mexico that correspond to significant differences in healthcare outcomes. Typically, regions in New Mexico with the greatest health outcome disparities also experience disproportionate provider shortages. New Mexico's healthcare workforce is concentrated in Bernalillo County, while the southern regions of the state tend to experience more pronounced shortages.

Chart 6. Distribution of Healthcare Workforce in New Mexico



Source: UNM & Licensing Boards

New Mexico's doctors are not equally distributed across the state. While the urbanized counties of Bernalillo, Santa Fe, and Dona Ana comprise roughly 49 percent of the state's population, over 58 percent of the state's primary care physicians practice in these counties. Similarly, 60 percent of the state's internal medicine specialists, 65 percent of its surgeons, and 65 percent of other specialists are concentrated in these three counties.

In an older but still relevant study, Johnson et al (2006) assessed disparities in provider availability in rural and urban areas and found that primary care physicians were over four times more available in urban areas than in rural New Mexico. Similar ratios were found for other physician groups, and the availability of registered nurses in urban areas was twice that of rural areas as well. New Mexico could explore ways that hospitals, particularly sole community providers, and managed care organizations may expand rural primary care networks.

Table 10. Urban/Rural Physical Health Provider Disparities in New Mexico

Provider Group	Rural		Urban		Disparity Ratio*
	Number	Ratio of Provider to Population	Number	Ratio of Provider to Population	
Primary care physicians	630	1:1824	1586	1:429	4.25
Family practice	229	1:5017	369	1:1843	2.72
OB/GYN	52	1:22095	127	1:5356	4.13
Emergency Medicine	47	1:24445	125	1:5442	4.49
Pediatrics	78	1:14730	271	1:2510	5.87
Internal Medicine	223	1:5152	629	1:1081	4.76
PAs	146	1:7869	163	1:4173	1.89
Registered nurses	2566	1:448	3581	1:190	2.36
NPs	231	1:4974	329	1:2068	2.41

Source: Administration and Policy in Mental Health and Mental Health Service Research

*Disparity ratio = number individuals served per provider in rural area divided by number served per provider in urban area.

The availability of NPs and PAs in urban areas is approximately twice that for rural areas, suggests 2006 data. Nursing licenses suggest that roughly 61 percent of NPs and 67 percent of PAs are concentrated in Bernalillo, Dona Ana, and Santa Fe counties. Again, licensure data does not specify practice location(s) but does tend to reinforce the notion that practitioners are more available in the larger, urban areas of the state.

According to information from NMRLD, the vast majority of dentists are concentrated in the urban areas of Albuquerque, Santa Fe, and Las Cruces. As stated in the 2008 Western Interstate Commission on Higher Education (WICHE), the dental workforce is designed to work primarily in private practice. This model has been successful for providers but, "has been ineffective in expanding access to dental care for underserved populations." According to NMHR, the majority of Albuquerque dentists are practicing in the northeast heights.

Behavioral health professionals (psychiatrists, psychologists and master's-level counselors are much scarcer in rural New Mexico than in urban centers. Psychiatrists are seven times more abundant in urban New Mexico than in rural areas in the state. Additionally, psychologists were almost six times more accessible in urban areas than in rural communities. Social workers were two and one-half times more prevalent in urban areas, and counselors were almost three and one-half times more prevalent in urban versus rural areas. Disparities have not likely changed significantly since this data was collected in 2006.

Table 11. Urban/Rural Mental Health Provider Disparities in New Mexico

Provider Group	Rural		Urban		Disparity Ratio*
	Number	Ratio of providers to population	Number	Ratio of providers to population	
Psychologists	104	1:11,047	366	1:1,859	5.94
Psychiatrists	54	1:21,276	229	1:2,970	7.16
Social Workers	1122	1:1,024	1672	1:407	2.52
Mental Health Counselors	680	1:1,690	1370	1:497	3.40

Source: Administration and Policy in Mental Health and Mental Health Service Research
*Disparity ratio = number individuals served per provider in rural area divided by number served per provider in urban area

Among several healthcare professions, existing temporary supply bulges will disappear in the near future. Despite current or projected shortages in all of New Mexico's healthcare professions, transitory factors presently create the illusion of an adequate supply.

The state's nursing shortage was more apparent prior to 2009, but the recession motivated nurses to return to the workforce, and the shortage waned. The impact of the recession may explain why current nursing graduates report difficulties finding jobs; Jeff Dye of the New Mexico Hospital Association reports that hospitals in the state have been conservative in filling nursing positions during uncertain economic times, and when they do hire, they tend to look for individuals with more experience. As the economy improves, however, there will be an "explosive need" for more nurses.

The pharmacy workforce is experiencing growth; in recent years, the number of U.S. pharmacy schools has expanded from 80 to 129. Nevertheless, because of the implementation of the ACA, the national pharmacist shortage will exceed 30 thousand by 2020 (UNM College of Pharmacy). As pharmacists take on expanded roles, which include prescriptive authorities and chronic disease management, estimating New Mexico's need for pharmacists becomes more difficult, however.

Dentistry is experiencing a recession of its own because of the growth of corporate dentistry and patient deferral of care. As a result, record numbers of dental practices are in bankruptcy. Yet, dentist production has increased in recent years. During the 1990's, a perceived glut in the number of dentists resulted in the reduction of eleven dental schools nationally. Since then, five schools have been established. Utah, in particular, has invested in dental programs and produced more dentists than the state needs, resulting in a bulge in New Mexico's urban dentist supply. As a result, FQHC executive directors report an excess of dentist job-seekers. However, the general supply and misdistribution of dentists in the state is expected to worsen over time as the population ages and retires.

Significant sectors of New Mexico's healthcare provider population are approaching retirement age. As New Mexico's population ages, its professional population is also aging and quickly approaching retirement.

Nearly one-third of the nation's physicians are expected to retire in the next decade. According to the Kaiser Foundation, approximately 24 percent of the nation's 1 million physicians are older than 55, and 21 percent are over age 65. The UNM Center for Workforce Analysis physician survey reveals that 38 percent of New Mexico-licensed doctors are age 55 and older, and 13.5 percent of New Mexico physicians plan to retire or to significantly reduce their patient care hours in the next 12 months. Another 4.3 percent plan to move out of state.

The American Medical Association expects that the number of elderly physicians will increase continue to increase as doctors work beyond traditional retirement age for personal and economic reasons, presenting the potential for problems. University of California gerontologist William Norcross cites the lack of mandatory competency evaluations for doctors and estimates that, "about 8,000 doctors with full-blown dementia are practicing medicine in the United States."

The general supply and maldistribution of dentists in the state are expected to worsen over time as the population ages. The New Mexico Dental Board reports that the average age of dentists licensed in the state is 51. Nationally, 6,000 dentists retire each year, while only 4,700 graduate annually. The New Mexico Health Action Alliance reports that our state is ranked first with respect to dentists age 55 and older (51 percent). However, according to the New Mexico Dental Association, dentists do not often walk away from the profession when they turn 65; they simply slow down. Thus, the dental bubble will not burst; it will simply deflate.

Nationally, both nurses and nurse faculty are rapidly approaching retirement age. According to the American Association of Colleges of Nursing (AACN), the average age of employed registered nurses is 43.3 years. In New Mexico, 42 percent of all licensed nurses are age 50 or older. The average age of nursing school associate professors is 52. The AACN points to average faculty age as a factor that will severely limit nurse production to meet future demand.

Determining nurse retirement rates in New Mexico is difficult and best estimated through re-licensure rates. The New Mexico Center for Nursing Excellence reports that the total number of new nurses (1,936) did not fully replace newly inactive licenses (2,685), suggesting the state's supply is dwindling.

Many professionals will not accept, or will continue to limit, the number of patients with Medicare and Medicaid in their practices. Nationally, the Government Accountability Office reports insufficient dentists, primary care physicians, and specialists willing to care for Medicaid and Medicare patients, while the National Center for Health Statistics reports that only two out of three primary care physicians are willing see new Medicaid patients. Practitioners are more willing to see new patients with Medicare or private insurance, though, and cite low reimbursement rates as major factors in their decisions to accept patients (Evans, 2012).

Nationally, Medicaid pays physicians approximately 59 percent of the reimbursement rate paid by Medicare for primary care services. In New Mexico, the Medicaid-to-Medicare ratio is better than average; the state has the 9th smallest discrepancy among the states, with Medicaid reimbursing 85 percent of Medicare rates for primary care (Kaiser, 2012). However, Medicare's reimbursement rate is about 80 percent of what commercial insurance pays (CMS, 2010). As 78 million baby boomers gain Medicare coverage over the next two decades, financial pressures may deter providers from serving the aging population, exacerbating existing shortages.

Given the growing shortage of healthcare professionals and their maldistribution across the state, New Mexico should expect some deterioration in access to health care, at least in the near term. Most New Mexicans will feel the pinch of an inadequate healthcare workforce as wait times increase**.** Much of the existing information regarding wait times to see doctors, dentists, and specialists is anecdotal as the state fails to systematically collect this information. The New Mexico Primary Care Association (NMPCA) recently conducted an informal survey of its member FQHC clinics regarding wait times for new patient appointments and found that 76 percent of sites reported wait times for initial, non-urgent, between one week and four weeks.

New Mexico should anticipate wait times will increase with the expansion of insurance coverage, as was seen in Massachusetts following healthcare reform; despite a greater physician supply, average wait times for primary care appointments and some specialty care exceeded 40 days. Other states are predicting similar situations; the California Academy of Family Physicians recently predicted that, "people should be expecting longer waits and shorter appointment times." Particular problems will be seen in areas already underserved, and most New Mexicans will likely feel the pinch of an inadequate healthcare workforce.

The remaining uninsured population and patients who cannot wait to see an assigned healthcare professional will continue to use hospital emergency departments (ED) to access care. In turn, EDs will continue to experience shortages of key professionals. With insurance coverage expansion in 2014, policymakers might anticipate a decrease in ED use for primary care. However, such decreases will not happen overnight because of gradual insurance uptake rates. Also, because of the continuing shortage of providers and lengthy wait times for new patients, the newly insured may continue to have problems accessing physicians and dentists. UNMH and the New Mexico Hospital Association anticipate that emergency departments will continue to see individuals using ED services for primary care, at least in the near future.

New Mexico should implement the following four strategies to improve the healthcare workforce supply: systems of delivery, recruitment and retention, education, and removing barriers to expansion. New Mexico needs an effective, multifaceted approach to expanding the healthcare workforce. Unless decisive action is taken to address our healthcare workforce issues, New Mexico can expect to experience continuing problems.

No single approach will provide a lasting solution; instead, a diverse, multifaceted strategy is required. Such a plan should include teams of professionals working to the full extent of their licenses, a robust recruiting and retention effort, and an approach to healthcare education that focuses on producing professionals in high demand fields. The state should also stimulate interest in healthcare professions among New Mexico's school children, enhance pipeline programs to facilitate entry into professions, and review all healthcare practice acts to reduce possible barriers to expanding the workforce. The fundamentals of such a targeted approach are in place in New Mexico but need to be strengthened.

Recommendations:

The Legislature and the UNM Health Sciences Center should work together to ensure adequate base funding for the New Mexico Center for Health Workforce Analysis at UNM.

The Legislature should ensure the Department of Health has adequate resources to carry out its statutory responsibility to conduct workforce planning. The Department of Health should collaborate with the New Mexico Center for Healthcare Workforce Analysis at UNM.

The Department of Health should provide periodic reports and recommendations on the state's health systems workforce, including the needs specific to individual regions of the state, the deployment of residencies, and the initiation of a comprehensive assessment of the numbers of practitioners needed across disciplines.

HEALTHCARE SERVICE DELIVERY MODELS MUST EVOLVE TO ADEQUATELY ADDRESS NEW MEXICO'S HEALTHCARE NEEDS

Service delivery systems will change to models that place the patient at the center of a coordinated system of care. A more effective approach to delivering healthcare should match healthcare practitioner skill to patient need to serve more clients at a lower cost.

The Affordable Care Act (ACA) envisions new patient-centered healthcare service delivery models which involve professionals working in teams to meet established patient outcome standards and reduce healthcare costs. The ACA established the Centers for Medicare and Medicaid Innovation to facilitate the development of new integrated care models, such a medical homes, to provide comprehensive, coordinated care. Additionally, HRSA is motivating New Mexico's FQHC's to adopt a medical home model of care.

The medical home (or health home) model comprises networks of providers addressing all of the patient's healthcare needs. Care coordinators (typically nurses or social workers) ensure that the patient accesses resources identified in an individualized care plan. Teams often receive a per-member-per-month fee with bonuses for meeting cost and care targets. The ACA also envisions increasing use of community prevention interventions and increase use of community health workers to promote positive health behaviors and outcomes. Additionally, telehealth may be used to connect remote practitioners to specialists, while emergency medical technicians (EMTs) may also be used to administer basic primary care services in communities which lack access to primary care. Eastern New Mexico University is currently piloting a community medic model in Eunice, Lovington, and Taos, which will train EMTs and paramedics to provide intervention and prevention services to promote community health and reduce costly emergency transports to hospitals.

Addressing the healthcare workforce problem requires an assessment of how the population uses healthcare. Half of the nation's population is basically healthy. According to the National Ambulatory Survey, one billion physician visits are made in the U.S. annually; 57 percent of these visits are made to primary care physicians. The most frequent principal reason for a physician visit is to receive a general medical examination.

Table 12. Most Frequent Principal Reasons for Physician Visits

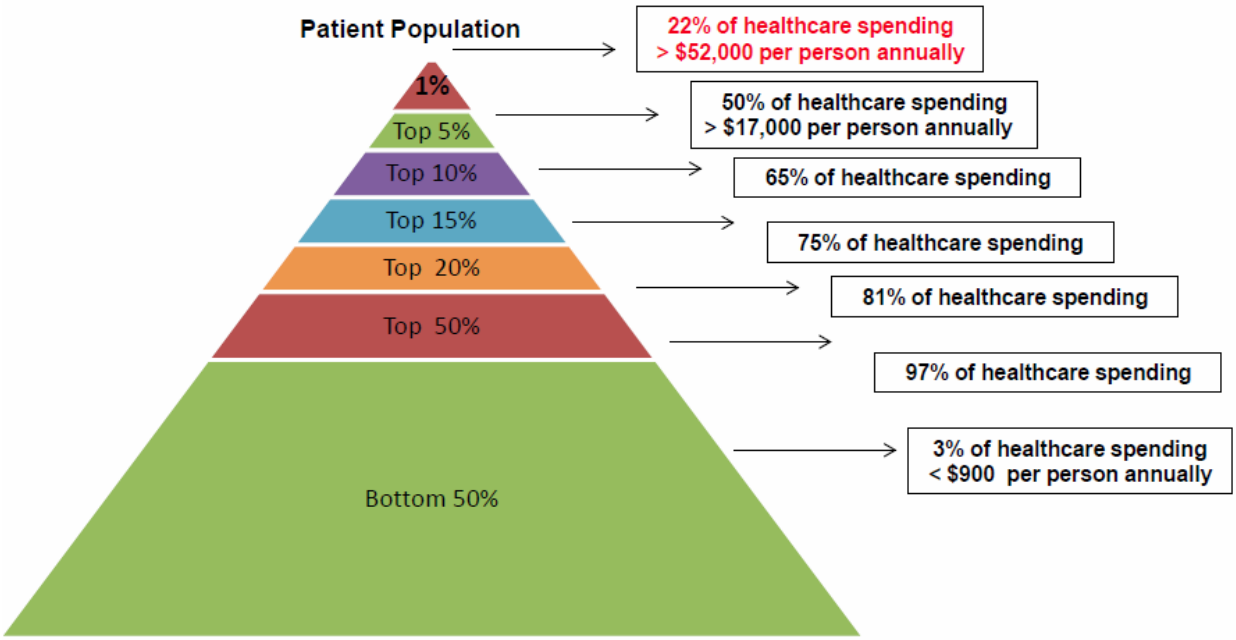
1. General medical examination
2. Progress visit, not otherwise specified
3. Cough
4. Post-operative visit
5. Unspecified test results
6. Counseling, not otherwise specified
7. Diabetes
8. Hypertension
9. Stomach pains
10. Symptoms referable to the throat

Source: National Ambulatory Survey

Patients with chronic health conditions require more specialty care and absorb a greater proportion of healthcare resources. As discussed below, 5 percent of the population, those with multiple chronic conditions, consume about half of the nation's healthcare resources each year.

A smarter service delivery model will target level of care to level of need. A new approach to health care delivery which targets complex, high-cost patients is evolving. Designing coordinated and comprehensive care for individuals who consume the majority of health resources helps mitigate health-related socio-economic barriers, ensures that patients with complex chronic diseases receive better care, and reduces costs. UNM's Dr. David Sklar envisions the growth of chronic care intensivists--doctors who specialize in the management of very complex chronic diseases and coordinate healthcare teams. These physician specialists may return complex patients individual to more stable, healthy lives and reduce the need for future hospitalizations and specialty care.

Figure 1. Concentration of Healthcare Spending in the U.S. Population



Source: Kaiser Family Foundation

The distribution of the U.S. patient population and corresponding use of healthcare resources is portrayed in Figure 1, as reported by the Kaiser Family Foundation. While other authors report slightly different annual spending levels in each category, the distribution of costs is well established.

- The top 1 percent of the patient population uses about 22 percent of healthcare resources, or an average $52 thousand per person per year. Individuals who account for this share of spending tend to have multiple chronic diseases along with diagnosed mental illness. These patients receive care within the existing healthcare system, but their care is often uncoordinated.

- Moving down the pyramid, the top fifty percent of the population, on average, uses 97 percent of the healthcare resources, about $4.5 thousand annually per person. Individuals with stable chronic conditions fall into this group. Patients over 65 years old are often in the upper 50 percent of the pyramid as elderly healthcare needs may increase six-fold.

- The bottom 50 percent of the population is basically healthy and requires only preventative care, such as flu shots, and occasional treatment for acute illness. The percent of the population that falls into this category consumes only 3 percent of the nation's healthcare resources, roughly $900 per person annually.

NPs and PAs can provide good health care to at least half of the population. The 50 percent of the population that is basically healthy can be cared for by NPs and PAs for most of their medical needs. Assuming the population also receives prevention services, such as wellness programs, and population-based public health services.

Patients with chronic diseases benefit from coordinated care models that employ a team approach. UNM's Care One program in Albuquerque is currently implementing a care coordination program for medically complex uninsured patients. In the Care One model, a primary care physician leads a team which includes case managers, community healthcare workers, and behavioral health specialists to help identified patients efficiently use the healthcare system and improve their health. UNMH refers patients have accumulated an excess of $144 thousand in medical charges within a 12 month period to the program. Care One then aims to stabilize these patients so that they may be turned over to the University's primary care clinics.

An analysis of 446 Care One patients determined that the program cut hospital admissions by almost 80 percent and emergency room visits by almost 60 percent. Patient outcomes also dramatically improved, and high-cost patients were better able to manage their own health.

Care coordination models may also be used to manage care and reduce costs in community settings. Hidalgo Medical Services (HMS) in Silver City and First Choice in Albuquerque serve as effective community-based models. Both providers attempt to bring highly coordinated care to their neediest patients, while building strong prevention models in communities. HMS and First Choice implement patient-centered, medical home models that match care to the healthcare statuses of patients; patients with multiple, chronic conditions receive case-coordination, specialist care, and services provided by community health workers. HMS also employs a broader, community-based health integration model that stresses prevention and healthy lifestyles attempts to address the underlying socio-economic factors that contribute to poor health. These models hold promise for a more effective healthcare system which reduces costs and improves health outcomes through targeted prevention and public health initiatives.

Recommendations:

Institutions of higher education and healthcare providers should ensure that public health approaches to individual and community-based services are fully integrated

NEW MEXICO NEEDS TO BETTER POSITION ITSELF TO RECRUIT AND RETAIN AN ADEQUATE WORKFORCE IN AN INCREASINGLY COMPETITIVE ENVIRONMENT

Current healthcare recruitment is not able to keep up with demand. New Mexico Health Resources (NMHR), a referral agency that finds eligible candidates and connects employers seeking practitioners, conducts much of the state's recruitment effort. NMHR principally recruits candidates for safety net providers, such as community health centers and critical access hospitals. During the last five years, 255 practitioner placements, including those of 108 physicians, 15 NPs, 26 PAs, and 85 dentists, resulted from NMHR referrals. While statewide provider vacancy rates are unknown, NMHR is currently recruiting for over 300 vacant positions. During FY12, NMHR reported an awareness of 602 vacant positions in New Mexico and estimates that they know of only one-third of the vacancies in the state.

Table 13. Known Safety-Net Vacancies Reported to NMHR February 2013

Physicians	157
Registered Nurses	11
NPs	46
PAs	18
LISWs	9
Pharmacists	14
Dental Hygienists	6
Dentists	30
Physical Therapists	7
Occupational Therapists	2

Source: NMHR

Table 14. FY12 Vacancies Reported to NMHR*

Physicians	59
LISWs	31
Medical Doctors	290
NPs	93
Occupational Therapists	6
Pharmacists	14
Physical Therapists	17
Physician's Assistants	29
Psychiatrists	23
Registered Nurses	29

Source: NMHR

*Excludes several position categories

New Mexico is not alone in its attempts to recruit providers. A 2010 survey conducted by the American Hospital Association revealed the following vacancy rates in hospitals nationally: 9 percent for various therapists and 4 percent for pharmacists and registered nurses. Additionally, 65 percent of hospitals reported efforts to increase the number of employed physicians, and 80 percent reported efforts to increase the number of employed primary care providers. The licensing survey of physicians practicing in the state reveals that only 17 percent attended medical school in New Mexico, suggesting that New Mexico recruits the majority of its physician workforce from out-of-state.

Practitioner recruitment is costly, however. Current literature suggests that the cost of recruiting a physician may range between $20 thousand and $123 thousand (Misa-Helbert et al, 2004). NMHR reports a considerably lower cost per placement, though specialty recruitment is more expensive. Recruitment estimates do not account for revenue lost because of vacant positions.

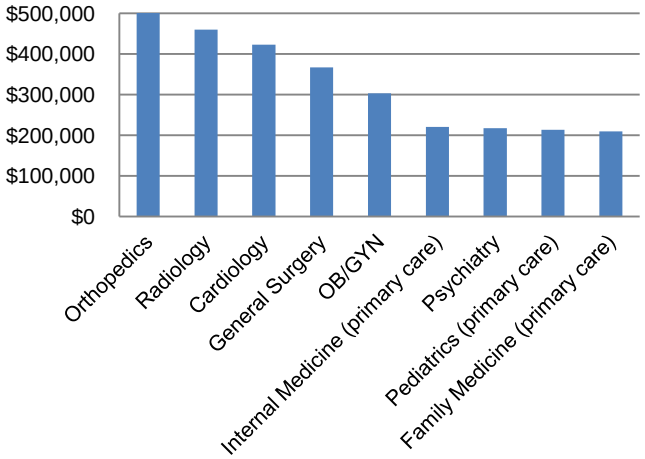
New Mexico also recruits a small number of J-1 visa physicians, who are foreign medical doctors that have completed medical training in the U.S. Typically, J-1 visa recipients must return to their home countries for a minimum of two years after completing medical education, but this requirement may be waived in exchange for three years of service in the state. DOH administers the waiver program and has approved 75 physician waivers in New Mexico since 2010. The state may grant 30 waivers annually, though 20 waivers must be to physicians practicing in shortage areas.

Special challenges exist in recruiting for rural areas and for specific professions and specialties. Attracting and retaining healthcare providers in rural areas has been a long withstanding challenge throughout the country and in New Mexico, prompting governments and medical education programs to pursue strategies that might attract and retain rural providers.

According to the American Association of Family Practice, the two strongest predictors that a physician will choose rural practice are specialty and background; family physicians are more likely than those with less general training to go into rural practice, and physicians with rural backgrounds are more likely to locate in rural areas than those with urban backgrounds. Research also suggests that several factors influence physician decisions to practice in rural communities, and these same factors presumably affect other healthcare providers as well. These factors include: training with a rural component, access to cultural and recreational activities in the community, spouse desires, and receptivity of other physicians in the community (Geyman et al, 2000).

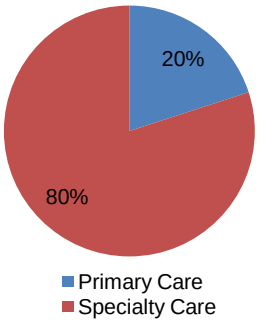
At the medical school level, recruitment into primary care is a considerable challenge because existing pay systems provide incentives for specialty care practice. According to the American Academy of Family Physicians, the annual income gap between primary care physicians and subspecialty physicians exceeds $135 thousand. Medical students understand the financial benefits of specialty practice and are increasingly selecting subspecialties over primary care, though implementation of the ACA will depend on primary care practitioners. The AAMC claims primary care physicians currently account for 35 percent of practicing medical doctors, but this number is rapidly declining; 20 percent of all U.S. medical students are now choosing primary care specialties. Without changes to medical payment structures, the supply of primary care physicians may further decrease, exacerbating recruitment challenges.

Chart 7. National Median Physician Salary by Specialty



Source: American Medical Group Association Compensation Survey

Chart 8. Reported Specialty of 2012 Medical School Graduates



Source: Journal of the American Medical Association

Loan repayment and other financial assistance programs provide incentives to encourage healthcare professionals to work in underserved areas and in primary care. Participation in state and federal programs, including the HED loan-repayment and loan-for-service programs, the New Mexico Health Service Corps, and the National Health Service Corps (NHSC), encourage practitioners to work in designated medical shortage areas.

Healthcare professionals, especially those with graduate and professional degrees, often graduate with considerable debt. According to the American Dental Education Association, the average debt of a dental school graduate exceeds $200 thousand, while the AAMC reported that the average 2012 medical school graduate held a debt load over $166 thousand. Student loan debt makes financial assistance and repayment programs appealing to practitioners, and existing programs effectively attract providers to underserved areas in New Mexico.

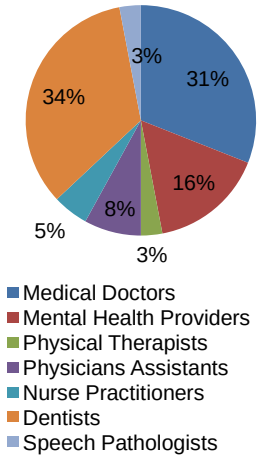
State-supported financial assistance programs effectively recruit providers and should be expanded. New Mexico funds several programs designed to recruit and retain primary care healthcare professionals to underserved communities. HED oversees the Health Professional Loan-for-Service and Loan-Repayment programs. In FY13, the state appropriated $1.4 million from the General Fund for these programs. According to HED, the default rate among loan repayment recipients is 2 percent, though the rate is higher among Loan-for-Service participants. Additionally, DOH sponsors the New Mexico Health Service Corps (NMHSC), which provides awards for practitioners who commit to two years of service in New Mexico. Twelve NMHSC received awards in FY13.

Table 15. State-Sponsored Financial Aid Programs

Program	Description	FY13 Awards	Award Amount
Health Professional Loan-for-Service (HED)	State-sponsored loans to students in exchange for service in areas of the state which experience health professional shortages. Students may receive loans for up to four years, and a portion of the loan is forgiven for every year of service, up to the full amount. Professionals must commit to a minimum of three years of service and begin working in a professional shortage area within six months of graduation. Penalties may be assessed if the service agreement is not satisfied. Allied health professionals, dental providers, nurses, and physicians are eligible for participation.	45	Physicians: $25,000 annually Nurses: $12,000 annually Allied Health Professionals: $12,000
Health Professional Loan Repayment (HED)	The program will pay its participants for the principal and reasonable interest accrued on loans obtained for educational purposes. Recipients must commit to practice full-time in a designated medical shortage area for two years.	48	$25,000 annually Up to $35,000 for recipients working in HPSA areas
New Mexico Health Service Corps (DOH)	Participants receive a stipend amount in exchange for two years of service in a designated HPSA. Sites include community health centers, rural health clinics, health departments, IHS, and the VA.	12	$20,000 per year for two years Non-physicians receive less

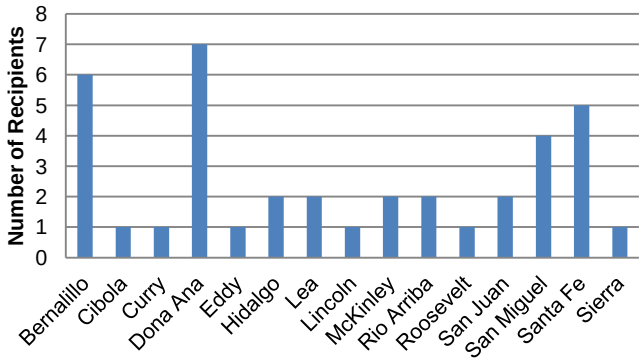
Source: HED

Chart 9. New Health Professional Loan Repayment Program Recipients in FY12
total awards= 22



Source: HED

Chart 10. FY12 Health Professional Loan Repayment Program Recipients by County of Service



Source: HED

Loan-repayment programs seem to provide a better return on investment than loan for service programs. A 2012 NHSC Collaborative retention study, which included New Mexico, reported that among NHSC clinicians, substantially more loan-repayment program participants than loan-for-service participants anticipate remaining in their service sites beyond their committed terms; 70 percent of loan-repayment participants report planning to remain a year beyond their commitment, whereas only 36 percent of loan-for-service program recipients anticipate remaining. HED reports that loan-repayment program participants are also less likely to default than loan-for-service recipients, and 98 percent of loan-repayment recipients complete their service obligations.

National research suggests, however, that while financial incentive programs bring health practitioners to rural communities, retaining award recipients beyond their commitments remains a challenge. Retention among non-NHSC physicians tends to be higher than NHSC physicians in rural communities (Geyman et al, 2000).

According to HED, interest in its Loan-for-Service and Loan-Repayment programs considerably exceeds available award funds. In FY13, HED received 138 applicants for 28 new award slots. According to the agency, applications for the healthcare loan programs have declined in recent years, and HED cites frustration among rejected applicants as the cause. In FY13, the Legislature appropriated $150 thousand to the student financial aid program of HED for the primary care physician conditional tuition waiver established by the Conditional Tuition Waiver for the Primary Care Medical Students Act. However, HED never promulgated rules for program implementation. The Legislature did not appropriate funds for the waiver program in FY14. While HED could request additional state or federal funding for the Health Professionals Loan-Repayment of Loan-for-Service programs, the agency did not in FY14.

Table 16. Unmet Need for Loan-for-Service and Loan Repayment Programs, FY 13

Medical LfS	27%
Nursing LfS	48%
Allied Health LfS	60%
Health Professional Loan Repayment Program	89%

Source: HED, estimated

The Western Interstate Commission for Higher Education (WICHE) exchange program supports the education of New Mexico's future dentists. WICHE allows dental students to attend participating out-of-state dental schools at a subsidized rate in exchange for three years of service in New Mexico. Partnering institutions reserve a specific number of dental school slots for New Mexico students, and the state pays the difference between out-of-state and in-state tuition at the partnering institution, an amount equal to roughly $23 thousand per student each year.

The number of WICHE slots awarded to New Mexico students is based upon legislative appropriations. HED reports that 92 percent of WICHE recipients return to New Mexico and complete mandatory service obligations, suggesting the program is effectively growing the state's dental workforce. During FY13, 14 new dental students received WICHE awards, and the state supported a total of 39 WICHE students who will be expected to return to New Mexico for future service.

Table 17. State Support for New Mexican Dental Students

2012-2013 Academic Year			
Program	**Total Number of Recipients**	**New Awards FY13**	**FY 13 Expenditures**
WICHE Loan for Service Dentistry	39	14	$1,035,000
Baylor School of Dentistry Loan	4	1	$54,000
TOTAL	**78**	**23**	**$1,978,200**

Source: HED

Funded by the U.S. Health and Human Services (HHS) Department, the National Health Service Corps (NHSC) provides stipends toward student loan repayment or scholarships for medical, dental, and mental health professionals working in health professional shortage areas (HPSA) around the county in exchange for a minimum of two years of practice. New Mexico Health Resources reports that 138 NHSC loan repayment participants and 28 NHSC scholarship recipients are currently serving in New Mexico. The number of NHSC practitioners serving in the state will decline in the near future as federal American Recovery and Reinvestment (ARRA) funds, which previously supported the program, have disappeared. NMHR also anticipates funding for NHSC will decline considerably under federal sequestration.

Table 18. NHSC Participants in New Mexico

Obligations ending 2013	93
Obligations ending 2014	59
Obligations ending 2015	5
Obligations ending 2016	8

Source: NMHR

Table 19. NHSC Working in New Mexico

Physicians	42
NPs	22
PAs	23
Certified Nurse Midwives	5
Licensed Clinical Social Workers	5
Dental Hygienists	9
Dentists	31
Licensed Professional Counselors	21
Psychologists	8

Source: NMHR

Recruitment in hard-to-staff areas appears to be a greater challenge than long-term retention. Retention for generalist physicians is minimally, if at all, different for physicians in rural HPSA areas and rural non-HPSA areas, suggests a 2004 study published in the *American Journal of Public Health*. Though research is limited, studies also suggest that retention rates among physicians in rural and urban areas are similar (Williams & Wilkins, 1993; Misa-Helbert et al, 2004). The National Rural Recruitment and Retention Network claims that 12 percent of all newly hired physicians leave their initial employment site within one year. One-third of physicians change practice arrangements within five years of the start of their careers (Vanasse et al, 2007). Coupled with studies that suggest fewer physicians move into shortage areas, these findings indicate rural shortage areas result primarily because of insufficient recruitment and not major differences in retention, as compared to urban areas.

Pipeline programs help develop a healthcare workforce for underserved areas. Research suggests certain individual characteristics are associated with provider decisions to practice in communities especially vulnerable to workforce shortages, including background and specialty preference. Minority providers play an important role in caring for minority populations, as studies indicate that black and Hispanic physicians are more likely than non-Hispanic whites to practice in physician shortage areas and to care for black and Hispanic patients (Saha & Shipman, 2006). Given New Mexico's diversity, the state has a considerable interest in recruiting and preparing a healthcare workforce that reflects the population.

Several programs around the state aim to recruit students into the healthcare pipeline before or during high school. UNM's Dream Makers program introduces middle and high school students to paths associated with health sciences through afterschool programs. The program currently operates in 13 communities around the state. UNM also supports diverse pre-healthcare students by providing courses to prepare for admission tests.

First Choice in Albuquerque plans to partner with a new health leadership charter high school to implement a curriculum that will allow high school students to gain exposure to health careers and earn certificate-level degrees. Finally, Hidalgo Medical Service's Forward New Mexico program supports career clubs, academic support, and enrichment programs for students in southwestern New Mexico. These pipeline programs will help stimulate interest in health science careers to address shortages in the long-term.

The BA/MD Program supports medical students beginning at the undergraduate level. The UNM BA/MD program was designed to address the state's physician shortages by assembling a class of diverse students committed to the needs of underserved communities. The program is a long-term investment; between FY06 and FY11, the state appropriated $15.7 million in for the BA/MD. Since FY11, state support for the BA/MD has been included in UNM's I&G funding. The first BA/MD class will graduate from UNM SOM in 2014 and begin residency programs.

Each year the program admits 28 students, and 50 percent of current program participants are minorities. Students who identify as minorities represent only 37 percent of the total UNM School of Medicine (SOM) population. While UNM hopes that BA/MD students will practice in New Mexico, students will not be penalized if they choose to work out-of-state. Students may apply for any residency program, though research suggests physicians tend to practice near their residency placement.

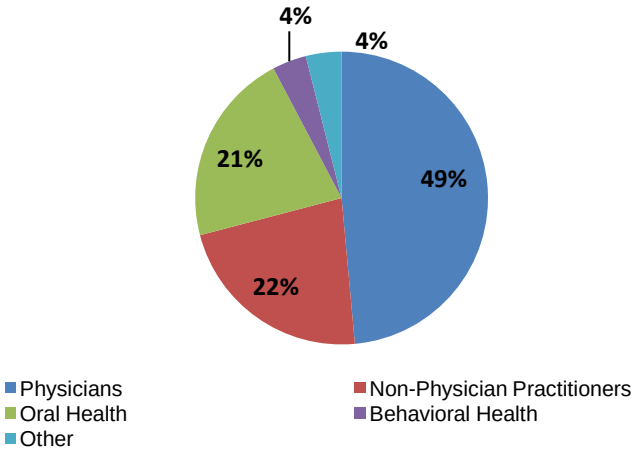
The UNM HSC has proposed a BA/DDS program as a more realistic alternative to building a dental school in New Mexico to address the state's shortage of dentists. Students would complete their undergraduate studies at UNM and then attend an out-of-state dental school under contract with UNM. Dental graduates would then return to UNM for dental residency. The UNM sought planning funds for this program in the 2013 Legislative Session. However, this effort was not successful.

Other potential recruitment and retention strategies are worth considering. In January 2011, the New Mexico Health Policy Commission (HPC) released a study with 12 recommendations to address healthcare workforce shortages in the state (see **Appendix B**). These strategies include a mix of additional stipends and rural community contracts, the enhancement of scholarships and loan repayment programs, the creation of graduate medical education residencies, and the expansion of mid-level provider programs in medical and oral health areas.

Tort liability limits provide incentives for healthcare professionals. New Mexico's Medical Malpractice Act limits a provider's personal liability and provides for informal hearings prior to court action. New Mexico's Medical Malpractice Act places a cap of $600 thousand on the aggregate dollar amount recoverable from any injury or death to a patient and establishes an informal hearing process that allows cases to be settled before ever going to trial. The New Mexico Medical Society thus reports that New Mexico's malpractice statute and procedures are more attractive to physicians than statutes in other states. The New Mexico Dental Association, however, expresses concern that dentists are not protected by the New Mexico's Medical Malpractice Act which may, in their opinion, deter recruitment.

New Mexico's rural tax credit provides a personal income tax credit to healthcare practitioners who provide services in underserved rural areas. During the 2010 tax year, DOH reported that a total of 1,726 recipients took advantage of this tax credit. Almost 50 percent of these were physicians.

Chart 11. Rural Healthcare Tax Credit Recipients



Source: NMDOH for 2010 Tax Year

Recommendations

The Legislature should identify a single agency, such as New Mexico Health Resources to coordinate all healthcare workforce recruitment activities for both the public and private sectors in New Mexico. Recruitment funding should be expanded to allow New Mexico to compete effectively with other states.

The healthcare workforce strategy committee under the auspices of the UNM Health Sciences Center should take into consideration the recruitment recommended strategies identified by the NM Health Policy Commission in its 2011 report, *Recommendations to Address New Mexico Healthcare Workforce Shortages*, the New Mexico Health Policy Commission recommended twelve strategies (see **Appendix B**).

The Legislature should increase funding for loan repayment programs for healthcare professionals as opposed to loan for service programs, which tend to have lower rates of retention.

EDUCATIONAL STRATEGIES MAY ALSO ADDRESS THE WORKFORCE SHORTAGE

New Mexico's public and private institutions do an admirable job of educating healthcare professionals, but cannot, by themselves, keep up with growing demand. Colleges throughout the state prepare students for work in healthcare professions; twelve of the state's public colleges offer registered nursing programs; all of the state's four-year institutions offer counseling programs, and three of the state's four-year institutions offer social work programs. UNM's Health Science Center houses many of the programs which prepare graduate-level health professions. However, New Mexico cannot simply educate its way out of the current healthcare workforce shortage.

Degree production in health care professions remained relatively stable between 2007 and 2011, with a few notable exceptions. Between 2007 and 2011, New Mexico educated over 4,700 registered nurses (RN's) at various levels. At the same time, New Mexico educated 263 medical doctors and 79 physician's assistants. The state also prepared over one thousand professionals who may provide behavioral health services, including social workers, substance abuse counselors, and counseling psychologists. The production of RNs declined slightly, while the production of physical therapists, occupational therapists, dental hygienists, and social workers increased during the same period.

Table 20. New Mexico Degrees Produced 2007-2011
(All Degree Levels Included)

	2007	2008	2009	2010	2011
Medical Doctor	54	53	54	53	49
Occupational Therapy	27	11	30	34	61
Pharmacy	85	88	82	84	86
Physical Therapy	15	21	43	38	25
PA	18	14	14	15	18
Radiography	88	73	64	74	68
Registered Nurses	1062	886	953	919	932
Social Work (MSWs)	199	193	191	192	206
Social Work (BSWs)	136	146	160	160	151
Dental Hygiene	35	50	51	57	59

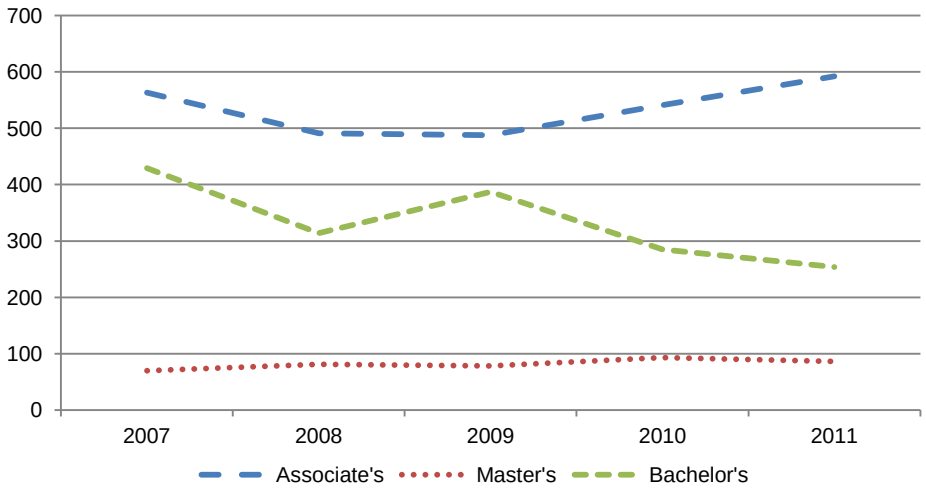
Source: LFC analysis of HED data

New Mexico has not increased the number of nurses educated by the state's public institutions, despite state and national calls for more nurses with bachelor's degrees. RNs may hold either an associate (ADN) or a bachelor-level (BSN) nursing degree. Nationally, 66 percent of all nursing graduates earn ADNs, as opposed to BSNs, but the 2011 *Future of Nursing* report released by the Institute of Medicine called for a more highly educated nursing force. The report recommended that 80 percent of the nursing workforce hold bachelor's degrees by 2020 to meet the nation's demand for health care.

New Mexico's colleges of nursing responded and aim to increase the production of BSNs. The 2011 LFC evaluation of the UNM HSC reported that approximately $16.5 million in supplemental funding was allocated to New Mexico's public institutions from FY04 to FY09 for nursing program enhancement through line-item appropriations to individual institutions, and $12.2 million was allocated between FY10 and FY13.

Despite support for the state's public nursing programs, fewer total nursing students have graduated in recent years. While the numbers of associate and master-level degrees awarded increased slightly between 2007 and 2011, the number of bachelor degrees produced in-state declined. The total number of RN degrees awarded decreased from 1062 in 2007 to 932 in 2011, when the effects of increased funding would be expected.

Chart 12. RN Degrees Awarded 2007-2011



Source: LFC analysis

Additionally, HED data reveal that few of the state's recent ADN graduates rapidly earn BSNs. Between 2007 and 2011, New Mexico institutions granted 2,675 ADNs and 1,669 BSNs. Of the 559 nurses who earned associate's degrees in 2007, 22 (4 percent) had earned a BSN by 2011. Economic factors may partially explain declining BSN production, as RNs with associate-level degrees and RNs with bachelor-level degrees make roughly the same amount in clinical practice.

However, the state Board of Nursing reports an increase in the first time completers of the National Council Licensing Exam (NCLEX), the test required to become a licensed RN in the state. Despite declining program graduates, the NCLEX increase suggests more RN candidates have sought licensure in recent years. The discrepancy between public institution nursing degree production and NCLEX growth may be explained by the expansion of proprietary nursing programs in the state or an influx of nurses from other states.

Table 21. Candidates for First Time Nurse Licensing Exam
Includes graduates from public and private institutions

	2007	2009	2011
ADN	616	673	826
BSN	242	186	177
Total	858	859	1003

Source: NM Board of Nursing

Graduates of various health programs differ in their decisions to practice in the state. To best meet the healthcare needs of New Mexicans, graduates should practice in regions with demand needs. Data from HED and the Department of Workforce Solutions reveal maldistribution among the practice patterns of recent graduates. Healthcare graduates with professional degrees are more likely to practice in Bernalillo County than graduates with associate or bachelor-level degrees. While only 54 percent of the state's recent nursing graduates practice in Albuquerque, over 70 percent of the state's newly prepared and practicing doctors, pharmacists, physicians assistants, and physical therapists remain in Bernalillo County.

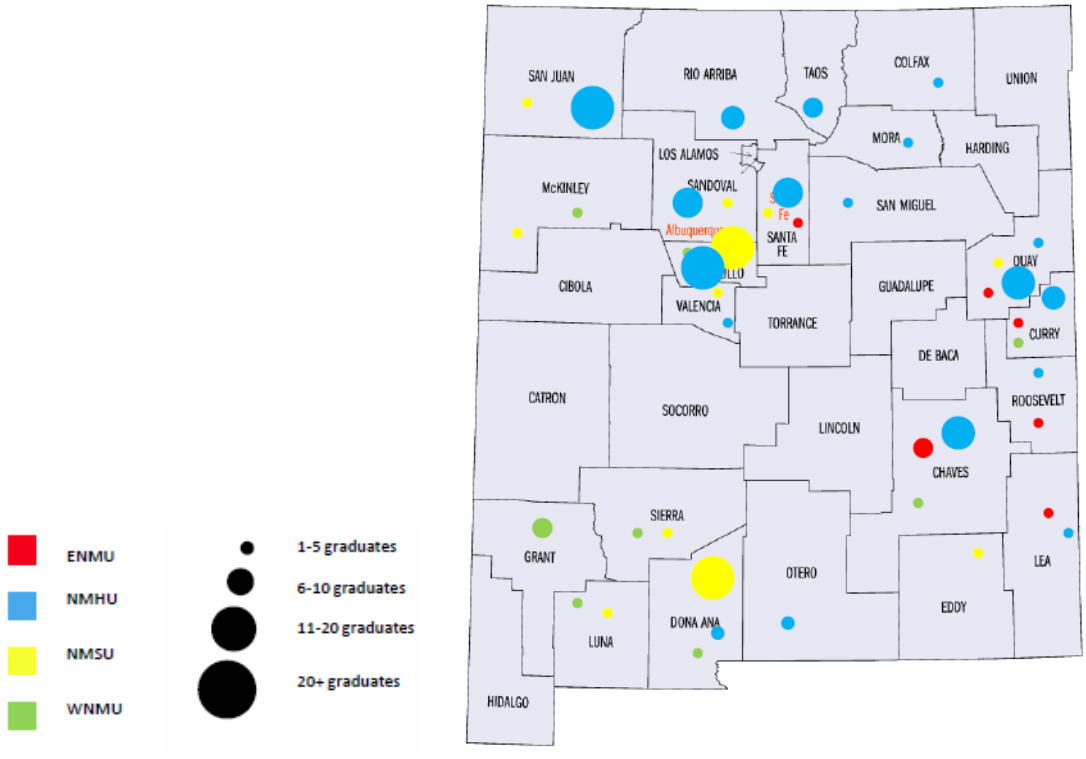
Table 22. 2007-2011 Health Care Graduates in the Workforce

	N	Percent Employed in Practice in New Mexico 2012	Other Employment Field in New Mexico 2012	Percent Practicing in Bernalillo County	Not Reported 2012
Certified Nurses Assistants	104	58%	3%	7%	39%
Counseling Psychology	49	63%	8%	4%	29%
Dental Hygiene	252	62%	37%	40%	0%
Medical Doctors	263	45%	0%	97%	55%
Occupational Therapy	163	70%	0%	62%	30%
Pharmacists	425	65%	3%	84%	32%
Pharmacy Technician	164	37%	25%	82%	37%
Physical Therapy	142	57%	1%	78%	42%
Physician's Assistants	79	61%	1%	73%	38%
Radiographers and Nuclear	367	63%	32%	56%	5%
Registered Nurses	4752	62%	17%	54%	21%
Social Work (BSWs)	753	15%	75%	38%	10%
Social Work (MSW)	981	41%	32%	53%	27%
Substance Abuse Counselors	44	27%	18%	25%	55%

Source: LFC analysis

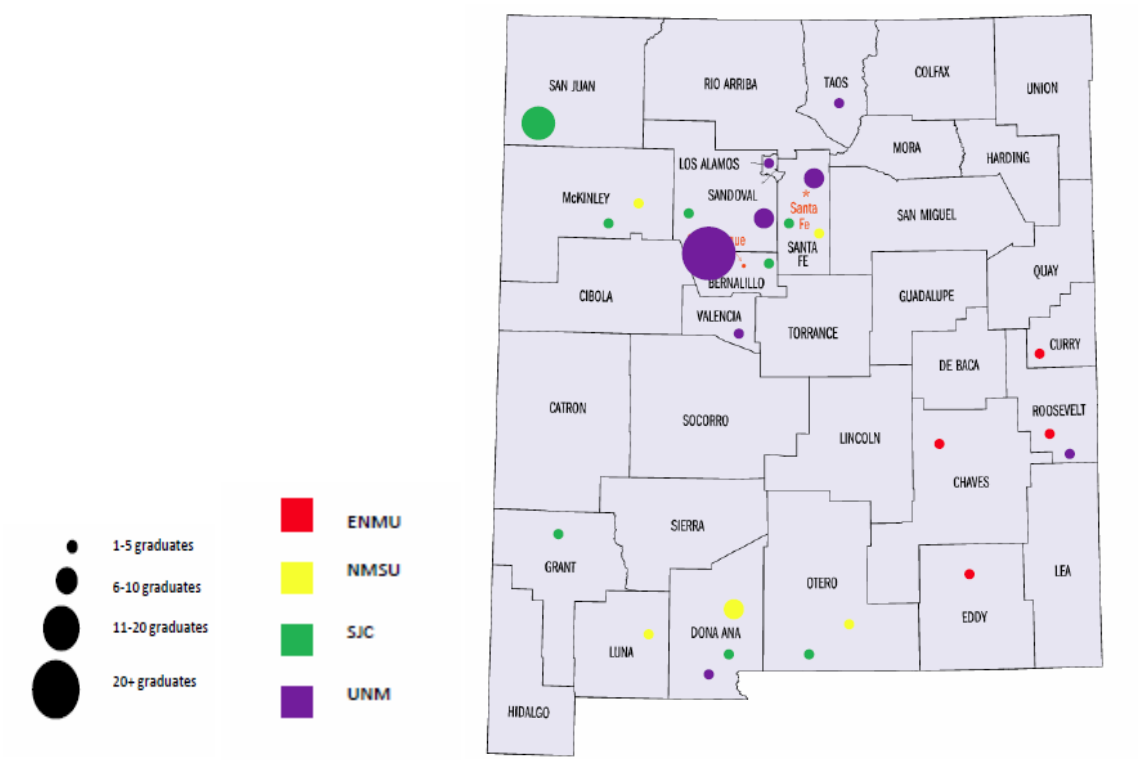
Inequitable provider distribution may be explained by the concentration of medical education within the UNM Health Science Center. While many of the state's institutions offer associate and bachelor-level programs, graduate and professional degree preparation remains concentrated in Albuquerque, potentially contributing to the maldistribution of health care providers. Across programs, recent graduates tend to practice near where they received training, supporting the notion that the state's colleges serve local workforce needs. Additionally, the concentration of specialty care in Albuquerque and the presence of the state's only level 1 trauma center may contribute to these patterns.

Figure 2. 2007-2011 Practicing Social Work Graduates by County and Program



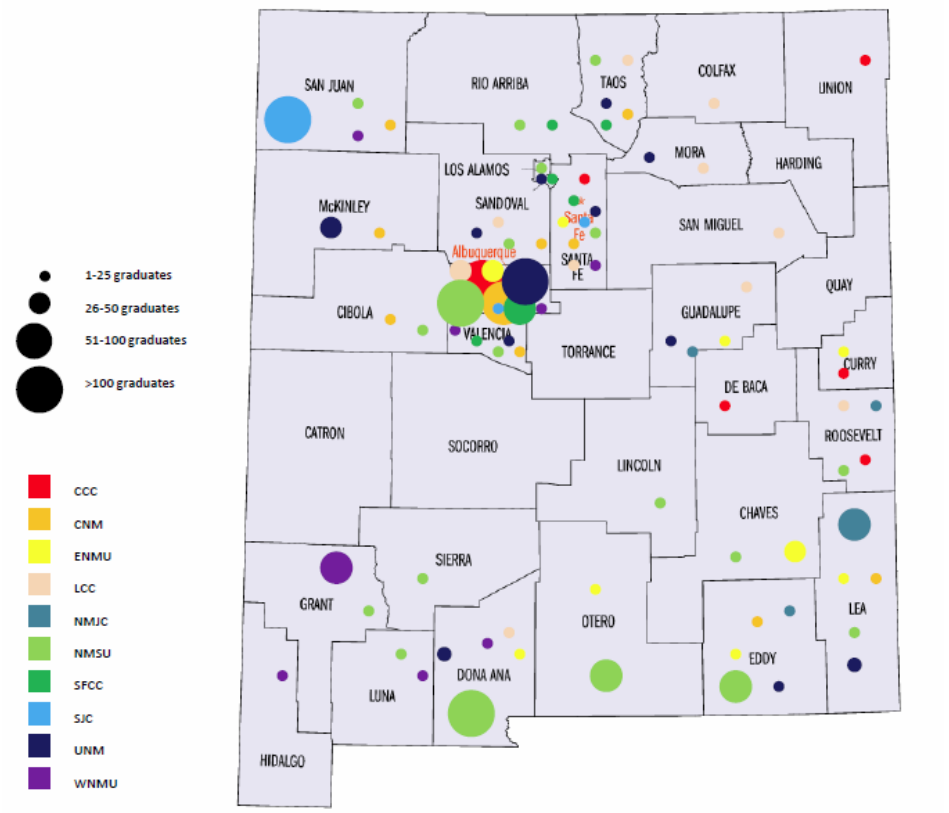
Source: LFC analysis

Figure 3. 2007-2011 Practicing Dental Hygiene Graduates by County and Program



Source: LFC analysis

Figure 4. 2007-2011 Practicing RN Graduates by County and Program



Source: LFC analysis

Graduate Medical Education residency caps severely limit the numbers of doctors produced in New Mexico and the United States. Physicians tend to begin practice in close geographic proximity to their residency placements, and primary care physicians are more likely than specialists to choose a practice location closer to their residency program (Geyman et al., 2000). These findings indicate strategic investment in residency positions may enable shortage areas to recruit physicians and the state to increase its physician workforce overall.

In 2006, the Association of American Medical Colleges (AAMC) recommended medical schools increase the supply of physicians by 30 percent to meet the patient needs of the new millennium. In response, medical schools around the country increased enrollment, but graduates cannot practice medicine without completing a residency program, also known as graduate medical education (GME).

GME is primarily supported through Medicare funds, and the total number of funded residency slots was capped by the Balanced Budget Act of 1997. The Centers for Medicare and Medicaid Services (CMS) currently contribute $9.5 billion annually to support the training of 94 thousand residents nationally. Medicaid and other sources, such as hospitals or states, fund roughly 10 thousand additional slots. Currently, the number of U.S. medical graduates exceeds residency slots, and the remaining positions are filled by graduates of U.S. osteopathic schools or foreign medical school graduates. At the current expansion rate of U.S. medical graduates, the AAMC predicts that the number of graduates from U.S. medical and osteopathic schools will exceed residency slots by the end of the decade, squeezing out applicants from foreign medical schools. This squeeze should alarm New Mexico because international medical graduates make up a disproportionate share of physicians practicing in rural communities.

The American Medical Association estimates that the direct cost to train one resident averages $100 thousand per year. UNMH funds 348.65 FTE residency slots, many of which are supported through CMS funds. UNMH reports exceeding the CMS cap by approximately 80 FTE in FY13. State I&G funds supported 8.1 family medicine residency FTE in FY13.

Nearly five hundred medical residents are working in New Mexico. According to the 2012 National Residency Match Report, 133 new residents matched in New Mexico, and UNM reports that 470 total GME FTE and 120 fellowships were funded in FY13. In 2012, residency programs in New Mexico were located in Albuquerque, Santa Fe, Las Cruces, and Roswell, though Roswell has since lost its accreditation and will not continue to receive residents in the future. In 2008, *House Memorial 2: State Funded Primary Care Residency Slots* recommended increasing the state's 25 family medicine residency slots by 50 percent using recurring general fund appropriations. Since 2008, total family residency slots in New Mexico remain unchanged.

All of the residency slots outside of UNM are devoted to family medicine. Twenty-five doctors began family medicine residency in New Mexico in 2012. While 171 (31 percent) of the residency and fellowship slots at UNM are classified as primary care, including internal medicine, general practice, and pediatrics, many of UNM's primary care residents go on to sub-specialize and ultimately practice specialty care. National trends indicate that only 20 percent of medical school students ultimately practice primary care, and 8 percent practice family medicine, though nearly half of all patient visits are to primary care providers. Institutions should develop and place residents based on where specific services are needed in the state.

Table 23. 2012 Resident Matches in New Mexico

Program Placement	2013 Resident Matches
UNM School of Medicine (Albuquerque)	121
Northern NM Family Medicine (Santa Fe)	3
Memorial Medical Center (Las Cruces)	6
Eastern NM Medical Center (Roswell)	3

Source: National Residency Match Program

Table 24. Total UNM Residency FTE Funded in FY13, by Specialty

Anesthesiology	31.17
Dermatology	6
Emergency Medicine	33.17
Family Medicine	54.76
General Dentistry	10.60
Internal Medicine	82.13
Neurology	12
Obstetrics/ Gyn.	26
Orthopedic Surgery	25
Pathology	17.7
Pediatrics	46.30
Psychiatry	36.85
Radiology	27.50
Surgery, General	34.50
Neurosurgery	11.66
Ophthalmology	2
Otolaryngology	5.75
Thoracic Surgery	0
Urology	7

Source: UNM HSC

National attempts to redistribute GME slots have failed in the past. The Medicare Modernization Act of 2003 sought to address ongoing physician shortages by gathering unfilled residency slots and redistributing for primary care and rural residency programs. However, many of the hospitals that received the redistributed slots were not located in rural areas or created new specialty positions instead. The ACA of 2010 similarly called for a redistribution of residency slots, though the GME cap was not lifted. Without accountability measures, efforts by state or federal governments to increase rural and primary care residency positions will likely fail because existing incentives favor specialty over primary care. The newly created New Mexico Residency Consortium, a collaboration among the state's residency program leaders, could serve a coordination and leadership role to ensure that residency allocations meet New Mexico's needs. Finally, funding alone will not remove all barriers for GME expansion as new programs must receive approval from the Accreditation Council of Graduate Medical Education.

The ACA provides new options for GME training which may benefit the state. The ACA created the Teaching Health Center Graduate Medical Education program to support the training of primary care residents and dentists prepared in community-based ambulatory care settings, such as FQHCs. The ACA provides $230 million over five years for direct and indirect expenses associated with the creation of 600 additional primary-care residencies. The resident slots created through Teaching Health Centers will not affect the capped GME slots and instead provide an opportunity for communities that experience provider shortages to attract new residents, though new programs must receive accreditation, and funding is only guaranteed through 2015. Hidalgo Medical Services in southwestern New Mexico is approved to become a Teaching Health Center.

Finally, expanding residency slots and increasing the physician supply is necessary but will not likely be sufficient to meet future demand. The AAMC notes that even a robust expansion of GME would not eliminate the physician shortage, and the nation will need to transform the way health care is delivered, financed, and used to overcome the projected physician shortage.

Existing nursing and dental residency programs are insufficient. Residencies are not a mandatory component of nursing or dental training, but graduates may elect to participate in residency programs to develop specialized skills and receive support as they transition into the clinical workforce. Residency programs also help attract practitioners to medically underserved communities.

UNM's dental residency program funnels practicing newly-educated dentists into New Mexican communities with dental care needs. Following dental school, residents undergo a one-year residency through UNM to develop advanced skills. Though increasing access to oral health care in underserved populations is not the primary goal of the program, residents gain clinical experience in hospitals and clinics which serve as safety net providers, and the program serves as a pipeline for dental providers in underserved communities. Thus, residency programs are a promising mechanism for recruiting providers to the state. Ten residents are accepted into UNM's program annually, at a cost of $125 thousand per resident. The state appropriated $1 million for the program in FY13. UNM reports that 70 percent of the residents accepted in 2012 were from New Mexico, and 62 percent of dental residents are retained in the state following program completion. According to program directors, UNM would require additional faculty and capital investment to expand the program.

The New Mexico Center for Nursing Excellence supports the New Mexico Rural Nurse Residency program through a partnership with the Northwest Rural Nurse Residency program at Iowa State University. The program is funded by a HRSA grant. Like the UNM dental residency program, nursing residents complete a one-year residency program to assist their transition into the workforce. Three cohorts of nurses are accepted each year and placed in facilities with fewer than 200 beds around the state. Ten nurses are currently completing residency, and 15 nurses have completed the residency program since 2010. The Center for Nursing Excellence estimates a retention rate that exceeds 90 percent in the year following residency completion, though program evaluation will officially be conducted by Iowa State. Nationally, turnover among first-year nurses ranges between 35 percent and 60 percent, reports the Robert Wood Johnson Foundation. Thus, the New Mexico Rural Nurse Residency program suggests promising results and may be a model worth replicating or expanding.

Recommendations:

The Legislature should consider passing legislation to expand state-funded family medicine residencies. To accomplish this objective, the Legislature should appoint a panel of industry experts to study realistic strategies including revisiting the recommendations made in the 2008 Health Policy Commission report on state funded family medicine residency slots. The study group should make recommendations to the Legislature no later than November 2013, taking the following into consideration:

- Funds should be used to establish new residency slots, not supplant existing residency positions.
- The majority of these new residencies should be located in rural or underserved areas of the state.
- State I&G funded residents should be encouraged to commit to practice in New Mexico following residency.
- Planning should include locations, costs, possible matching revenue from Medicaid managed care organizations, and other medical groups, expected benefits, and reporting and accountability measures.

The Legislature should expand funding for WICHE slots to train additional dentists for New Mexico.

The Legislature should also examine the expansion of state-funded rural dental and nursing residencies in New Mexico.

New Mexico's public universities should report on the feasibility of creating additional master's-level clinical nursing programs to increase the state's NP supply.

REGULATORY AND PRACTICE BARRIERS PREVENT THE FULL EXPANSION OF NEW MEXICO'S HEALTHCARE WORKFORCE

The impact of doctors and dentists can be effectively extended through the expanded use of NPs, PAs, and non-dentist practitioners. Part of any healthcare workforce strategy should involve an examination of professionals whose roles can be further expanded to extend the impact of the healthcare team. Plans should also identify and reduce barriers to workforce expansion.

New Mexico should train more advanced practice professionals as force multipliers to help address healthcare needs. New Mexico will not likely be able to recruit or prepare a sufficient number of physicians to meet care demands. While working to increases its physician supply, the state should further develop its supply of NPs (NP) and PAs (PA). NPs and PAs already extend the physician workforce; 970 are licensed to practice in New Mexico, and many are effectively deployed in rural areas of the state. Similarly, New Mexico's 570 licensed PAs, although slightly less independent than NPs, are filling roles in primary care as well as assisting in specialty areas, such as surgery. Studies comparing the quality of care provided by physicians and NPs consistently confirm clinical outcomes of patients served by NPs and primary care physicians are no different (Mundinger et al, 2000; Kirkwood, Coster & Essex, 2006). Expanding the workforce with NPs and PAs could greatly ease New Mexico's physician shortage. Currently, UNM and New Mexico State University (NMSU) prepare NPs, while only UNM prepares PAs.

Table 25. New Mexico Institutions Offering Advanced Primary Care Training

	Physicians	NPs	PAs
Public	UNM SOM	NMSU UNM	UNM SOM
Proprietary		University of St. Francis	University of St. Francis

Source: LFC

New Mexico's limited production of NPs and PAs will inhibit the state's ability to expand its primary care workforce. NPs and PAs may perform approximately 70 percent to 80 percent of the procedures typically performed by a primary care physician, yet they may be trained more quickly and cheaply. While medical doctors must complete four years of medical school and a minimum of two years of residency before they are able to practice independently, an NP may be trained in approximately two years after earning a BSN, and a PA requires roughly two years of graduate-level training. NCSL estimates that NPs can be trained at 20 to 25 percent of the cost to train a physician, while a previous LFC evaluation of the UNM HSC estimated that the cost to educate a physician exceeds $500 thousand. The UNM College of Nursing estimates educating a BSN-level nurse to the NP level costs roughly $64 thousand.

Appendix G compares the professional scope and training required to produce physicians, NPs, and PAs and demonstrates that augmenting the state's healthcare workforce with NPs and PAs will be faster and cheaper than exclusively training doctors. However, New Mexico's production of NPs and PAs lags behind its production of medical doctors; between 2007 and 2011, UNM graduated 97 NPs and 79 PAs. NMSU graduated 137 NPs during the same period. The University of St. Francis graduates approximately 25 NPs and 30 PAs annually.

Table 26. Advanced Primary Care Training at UNM

	Length of Study After Bachelor's	Credit Hours	Approximate Total Tuition Cost
Physicians	6+ years	4 years/ full-time	$65,000
NPs	2 years	54-56	$31,000
PAs	27 months	86	$32,000

Source: UNM

Table 27. Advanced Care Providers Educated by Public New Mexico Institutions, 2007-2011

All Physicians	263
NPs	234*
Physicians Assistants	79

Source: HED

*Includes Certified Nurse Specialist graduates

The state needs to address barriers that prevent the expansion of NP training programs. Despite lower educational costs, the state's production of physicians continues to surpass that of NPs. Colleges of nursing cite several significant barriers that prevent program expansion.

Qualified nursing faculty serve as a barrier to expanding the nursing workforce. The shortage is healthcare professional faculty is cited as a significant barrier to expanding the clinician workforce nationally. Nurse educators must have master's degrees, at a minimum, to prepare associate's or bachelor's-level nurses.

Colleges of nursing and the state's nursing associations continue to cite nursing faculty shortages as a major barrier to expanding the nursing workforce, and UNM reports that schools must maintain a one to six faculty-to-student ratio in clinical courses for accrediting purposes. Colleges of nursing also report that the discrepancy between nursing faculty salaries and clinical nursing salaries is a significant barrier to attracting qualified faculty, and the HJM 40 report issued in 2009 cited nursing faculty salaries as a major barrier to expanding the nursing workforce. Since 2009, average nursing faculty salaries reported by the Department of Workforce Solutions have increased nearly 15 percent. Other states have attempted to address the shortage of nursing faculty through tuition assistance or repayment programs for clinicians considering teaching and other strategies including mentoring and partnerships with health care institutions.

Table 28. Nursing Salaries

Position	Average Salary
Instructor/ Lecturer (UNM HSC)	$78,336
Tenure Track Faculty (UNM HSC)	$89,883- $135,269
Instructor/Lecturer (NMSU)	$53,700
Tenure Track Faculty (NMSU)	$71,784
Instructor/Lecturer (SFCC)	$40,484 - $47,415
Nursing Instructor (statewide average)*	**$65,348**
Practicing Clinical Nurse (NM average)	$68,107
Practicing Clinical Nurse (national average)	$70,610
NP (NM average)	**$86,000**
NP (national average)	$90,583

Source: UNM HSC, Workforce Solutions, and Salary.com

* As reported by Workforce Solutions. Includes proprietary institutions

Healthcare education trends may further constrain the number of professionals providing direct care. Academic and professional communities increasingly call for advanced and professional degrees as entrance into practice requirements. While increasing academic requirements will ensure more extensive training for providers, new requirements may also limit the number of providers able or interested in providing direct care. In recent years, academic creep has affected allied health professions; both pharmacists and physical therapist must now earn doctoral degrees to enter practice.

New Mexico's nursing educator programs have worked through New Mexico Nursing Education Consortium (NMNEC) to develop a standardized ADN and BSN curriculum that will be adopted by all of the state's public institutions and facilitate student progression from ADN to MSN. Through collaboration, students at the state's community colleges will complete three years of training at the community college level, and then take a final year of courses at either UNM or NMSU, earning a BSN after four years. An efficient ADN to MSN pipeline is essential to provide nurses with the level of training required to enter practice as a NP, and an increase in BSNs will provide a larger pool of nurses who may earn master's degrees. UNM and NMSU currently offer graduate-level nursing programs, and ENMU is developing a master's level nurse-educator program.

Both NMSU and UNM have moved toward replacing master's-level nursing programs with doctoral-level programs. While this shift will increase the supply of nurses with advanced degrees who may serve as faculty, requiring practicing nurses to obtain doctorate-level degrees will reduce the supply of NPs and advanced practice nurses available to provide direct services.

The state's colleges and nursing organizations also identified the following as additional barriers to expanding the NP supply:

- Lengthy and cumbersome credentialing processes, delaying and preventing NPs from practicing;
- Differences between physician and NP reimbursement for identical procedures;
- Insufficient clinical sites and clinical proctors.

To address insufficient clinical sites, several states, including Michigan, Tennessee, and Oregon, have developed centralized clinical placement agencies which coordinate health care institution and education institution needs. To provide financial incentives for institution participation in clinical placement, Colorado has considered institution subsidies and tuition increases to pay clinical sites. To reduce credentialing barriers, NCSL suggests that instituting a single process for verifying and credentialing providers may streamline the process and reduce administrative health costs.

The state should also examine regulations which may limit providers from working to the full extent of their licenses. New Mexico's nursing scope of practice act is one of the most expansive in the county and serves as a model for other states. New Mexico is one of 18 states which allows NPs to practice independently. Practice acts for other healthcare professionals are not as expansive, however.

Modifying regulatory statutes that govern other advanced practice providers, including PAs and prescribing psychologists, may help eliminate barriers to full practice. Like NPs, PAs may be trained much more quickly than doctors, and their training is relatively inexpensive. However, PAs must work under the supervision of a physician, though the supervising physician need not be present when a PA practices. In New Mexico, PA scope of practice is more limited than that of NPs, though PAs can examine, prescribe, and treat patients. Prohibiting independent PA practice may thus serve as a barrier to expanding this workforce. PAs are licensed by the New Mexico Medical Board to practice as part of a physician-led team.

Similarly, New Mexico allows for specially trained, doctoral-level psychologists to prescribe medication in consultation with primary care physicians. Presently, 39 prescribing psychologists are licensed in the state. Practitioners report that the supervision required for independent prescribing practice may limit the supply of prescribing psychologists. Prescribing psychologist supervision barriers should thus be further examined for possible ways to expand this workforce as a method to assist psychiatrists, a critical shortage area in New Mexico.

New Mexico should examine barriers to expanding the state's supply of master's-level behavioral health counselors. The state must move quickly to remove possible barriers to expanding the behavioral health workforce by streamlining restrictions on mental health counselor reciprocity, expanding capacity for clinical supervision, and expanding the activities that can be reimbursed under Medicaid, such as case consultation. The behavioral health master's degrees that qualify for licensure in New Mexico are limited to social work and several counseling areas. Other states, including Arizona, Colorado, and Oregon, have expansive licensure regulations that allow more professionals to provide care by accepting a wider array of mental health master's-degrees, including various counseling and psychology degrees, to qualify for supervision and licensure. Oregon's Qualified Mental Health Professional designation is a model worth considering to expand the state's pool of mental health counselors.

Telehealth may also facilitate the supervision of counselors seeking licensure in areas where an on-site supervisor is difficult to arrange. Supervision, particularly in remote areas, is challenging but is crucial to the training and licensing of independent providers who may bill for mental health services. To become a Licensed Independent Social Workers (LISW), Licensed Masters Level Social Workers (LMSW) must complete 3.6 thousand clinical hours under the supervision of an LISW. Supervision must occur in person and is costly and time-consuming. Exploring telehealth models of clinical supervision may reduce barriers to the acquisition of LISW status. The New Mexico branch of the National Association of Social Workers suggests telecommunication may be an effective way to facilitate the supervision of LMSWs seeking licensure at remote sites and increase the supply of behavioral health providers in New Mexico.

New Mexico may expand the dental workforce through the use of trained professionals working under the guidance of dentists. In 2011, legislation to allow dental hygienists to take on additional dental duties, such as administering local anesthesia in prescribed situations, was passed. The New Mexico Dental Board has since adopted rules on these expanded hygienist functions. However, the state has not established training programs and lacks faculty to prepare expanded hygienists. Developing the capacity to train dental hygienists for expanded functions would enable the extension of the dental workforce. The Legislature should also revisit the concept of dental therapists as an additional way to provide care to under-served areas under the supervision of dentists.

Recommendations:

New Mexico's healthcare licensing boards should conduct a comprehensive review of all healthcare professional practice acts to judiciously reduce barriers to workforce expansion.

The New Mexico Medical Board should revisit the scope of practice for PAs to allow these professionals the same degree of independence that NPs are allowed in the state. PAs should be allowed this independent practice status after completing three to five years of clinical supervision by a physician.

The New Mexico Dental Board should coordinate planning that will provide programs to train dental hygienists in the expanded practice skills that are now allowed in administrative rule.

The New Mexico Psychological Board should examine the regulatory steps required to become a full-fledged prescribing psychologist to reduce the two years that are currently required as a "conditional" prescribing psychologist. After training, completing 400 hours of clinical supervision, and passing the required examination, prescribing psychologists should be allowed to practice in consultation with a primary care physician.

The New Mexico Regulation and Licensing Department should explore rules to expand the number of mental health masters degrees that qualify for supervision and licensure – using Arizona, Oregon and Colorado as examples.

The New Mexico Regulation and Licensing Department should consider ways to streamline the requirements for mental health counselor reciprocity with other states to facilitate adding experienced professionals to the New Mexico workforce and study ways to expand the capacity for clinical licensure supervision – including the creation of rules to allow the supervision of master's level therapists (LPCCs and LMSWs) to take place via telecommunication technology at sites where a licensed supervisor cannot be physically present.

The New Mexico Legislature should revisit the concept of dental therapists as an additional way to provide dental care to underserved areas, under the direction of supervisory dentists.

The New Mexico Legislature should create a single state-wide credentialing agency for healthcare professionals and require that all healthcare insurers operating in the state use the agency for credentialing purposes.

New Mexico's public major should <u>not</u> require all NPs to earn a doctorate degree. In addition to the emerging Doctor of NP degree program, New Mexico's public institutions should maintain master's-level clinical nursing programs to ensure an adequate supply of NPs providing direct care.

APPENDIX A: Evaluation Objectives, Scope And Methodology

Evaluation Objectives:

This evaluation examines the adequacy of New Mexico's healthcare workforce to meet the demands of the Affordable Care Act when it is implemented in 2014. The evaluation also looks at the adequacy of the healthcare workforce to meet longer-range demands associated with population growth and aging.

Objective 1: Assess the demand for healthcare workers stemming from the expansion of insurance coverage with the Affordable Care Act and with Medicaid expansion in New Mexico. Also access the longer-range demand associated with population changes. Determine the current and projected supply of healthcare professionals in New Mexico, including physicians, NPs, PAs, registered nurses, dentists, dental hygienists, psychologists, and masters-level behavioral health counselors. Also assess potential barriers to expanding the healthcare workforce.

Objective 2: Assess how healthcare service delivery systems will need to change to address New Mexico's healthcare needs.

Objective 3: Assess the current training and education of healthcare professionals in New Mexico.

Objective 4: Assess current recruitment and retention activities for New Mexico's healthcare workforce

Scope and Methodology:

- Interviewed healthcare professionals organizations, associations, licensing boards, educators, recruiters, and other key individuals to obtain a picture of the adequacy of New Mexico's healthcare workforce.
- Obtained and analyzed data from the NM Higher Education Department regarding the education and working status of selected healthcare professionals in New Mexico.
- Obtained physician survey data from the New Mexico Center for Health Workforce Analysis at the UNM HSC.
- Researched national literature dealing with all aspects of the healthcare workforce and emerging demand.

Evaluation Team:

- Jack Evans, Program Evaluator, Project Lead
- Rachel Mercer-Smith, Program Evaluator

Authority for Evaluation: LFC is authorized under the provisions of Section 2-5-3 NMSA 1978 to examine laws governing the finances and operations of departments, agencies, and institutions of New Mexico and all of its political subdivisions; the effects of laws on the proper functioning of these governmental units; and the policies and costs. LFC is also authorized to make recommendations for change to the Legislature. In furtherance of its statutory responsibility, LFC may conduct inquiries into specific transactions affecting the operating policies and cost of governmental units and their compliance with state laws.

Exit Conferences: The contents of this report were discussed with the Department of Health and with other key participants on April 4, 2013.

Report Distribution: This report is intended for the information of the Office of the Governor; the New Mexico Department of Health; Office of the State Auditor; and the Legislative Finance Committee. This restriction is not intended to limit distribution of this report, which is a matter of public record.

Charles Sallee
Deputy Director for Program Evaluation

APPENDIX B: HPC Recommendations

In its January 2011 report, *Recommendations to Address New Mexico Healthcare Workforce Shortages*, the New Mexico Health Policy Commission recommended twelve strategies:

1. Expand New Mexico Health Services Corps to provide additional stipends and community contracts to encourage rural practice
2. Expand the New Mexico Health Professional Loan Repayment Program
3. Expand the New Mexico Loan-for-Service Program
4. Establish a Primary Care Physician conditional tuition waiver program
5. Promote legislation to tax alcohol, tobacco or sugared soft drinks to fund healthcare loan reimbursement programs
6. Explore ways to promote a more diverse healthcare workforce
7. Expand the number of federally subsidized Graduate Medical Education residency slots
8. Support the development of mid-level oral health providers
9. Promote legislation to create 60 lottery scholarship slots for NPs and PAs who agree to work in NM for 3 years
10. Create a state entity to coordinate health professional workforce needs and efforts
11. Support efforts to track the health workforce
12. Expand New Mexico mid-level provider training programs

Bernalillo	310
Catron	0
Chaves	8
Cibola	4
Colfax	3
Curry	3
De Baca	0
Dona Ana	29
Eddy	7
Grant	19
Guadalupe	0
Harding	0
Hidalgo	1
Lea	6
Lincoln	1
Los Alamos	10
Luna	3
McKinley	12
Mora	0
Otero	10
Quay	0
Rio Arriba	13
Roosevelt	1
San Juan	30
San Miguel	6
Sandoval	23
Santa Fe	48
Sierra	5
Socorro	2
Taos	19
Torrance	0
Union	0
Valencia	4
Total	577

Source: NM Medical Board

APPENDIX D: Registered Nurses Licensed by County, 2012

Bernalillo	7,678
Catron	26
Chaves	504
Cibola	132
Colfax	99
Curry	384
De Baca	16
Dona Ana	1,864
Eddy	471
Grant	366
Guadalupe	31
Harding	3
Hidalgo	13
Lea	440
Lincoln	170
Los Alamos	179
Luna	108
McKinley	539
Mora	41
Otero	478
Quay	55
Rio Arriba	217
Roosevelt	108
San Juan	975
San Miguel	347
Sandoval	1,550
Santa Fe	1,453
Sierra	79
Socorro	83
Taos	290
Torrance	81
Union	36
Valencia	586
Total	19,402

Source: NM Nursing Board

Bernalillo	410
Catron	0
Chaves	29
Cibola	7
Colfax	7
Curry	19
De Baca	1
Dona Ana	103
Eddy	26
Grant	13
Guadalupe	2
Harding	1
Hidalgo	1
Lea	22
Lincoln	9
Los Alamos	8
Luna	8
McKinley	18
Mora	2
Otero	10
Quay	6
Rio Arriba	14
Roosevelt	5
San Juan	22
San Miguel	12
Sandoval	68
Santa Fe	81
Sierra	3
Socorro	7
Taos	23
Torrance	4
Union	4
Valencia	25
Total	970

Source: NM Board of Nursing

APPENDIX F: Oral Healthcare Providers Licensed by County, 2013

	Dentists	Hygienists
Bernalillo	446	434
Catron	1	0
Chaves	24	23
Cibola	7	9
Colfax	5	4
Curry	23	22
De Baca	1	1
Dona Ana	97	95
Eddy	15	21
Grant	15	13
Guadalupe	0	1
Harding	0	0
Hidalgo	0	0
Lea	11	14
Lincoln	10	4
Los Alamos	15	12
Luna	6	7
McKinley	17	8
Mora	0	1
Otero	14	14
Quay	1	2
Rio Arriba	4	10
Roosevelt	3	4
San Juan	71	77
San Miguel	9	9
Sandoval	69	72
Santa Fe	122	80
Sierra	5	4
Socorro	3	1
Taos	19	13
Torrance	2	4
Union	0	0
Valencia	21	44
Total	1036	1003

Source: NM Dental Board

APPENDIX G: Primary Care Provider Comparison

	Length of Training after Bachelor's Degree	Clinical Training	Approved Procedures	Independent Practice	Median Annual Salary	Reimbursement	Practice Specialty
MD	6+ years	3+ years in clinical and residency training	May examine, diagnose, and treat patients; may prescribe medication; may perform surgery and other invasive procedures; may order related therapies, screenings, and hospice care; may admit patients for in-patient hospital care and may pronounce death. Scope of practice determined by the Medical Practice Act.	Yes	$185,000	According to insurance fee-schedule	35% work in primary care, nationally
NP	2-3 years	NPs must hold a BSN prior to earning an advanced degree and thus often have years of clinical experience	May serve as a primary care provider and examine, diagnose and treat patients; may prescribe medication; may order screenings and related therapies; may assist in surgery; Cannot perform invasive procedures, such as colonoscopies or tumor biopsies; may not order home health or hospice care; may not admit patients for in-patient hospital care; may pronounce death.	Yes	$86,000	Medicare reimbursement if typically 85% of physician fee-schedule	75% work in primary care, nationally
PA	27 months, full-time after bachelor's degree	9-15 months	Specific services provided are agreed upon by the PA and supervising physician and must conform to the Medical Practice Act. May examine and treat patients; may prescribe and administer medication under the direction of a physician; may assist in surgery but cannot independently suture major lacerations or manipulate fractures if the procedure requires general anesthesia; cannot perform invasive procedures, such as colonoscopies or tumor biopsies; may not order home health or hospice care; may not admit patients for in-patient hospital care; may not pronounce death.	Physician remains the head of the practice. PAs must be supervised by a physician. The physician need not be on-site but the PA should have prompt access to the physician	$75,000	Medicare reimbursement is typically 85% of physician fee-schedule	32% work in primary care, nationally

Source: LFC analysis

APPENDIX H: Active Physicians in New Mexico

County	Primary Care	Internal Medicine	Surgical	Other Specialty	Unknown
Bernalillo	587	267	224	897	1
Catron	1	-	-	-	-
Chaves	45	11	10	47	-
Cibola	19	-	1	4	-
Colfax	9	-	2	6	-
Curry	24	5	9	11	-
DeBaca	-	-	-	1	-
Dona Ana	111	32	32	116	-
Eddy	27	5	11	24	-
Grant	23	2	5	23	-
Guadalupe	2	-	-	-	-
Harding	-	-	-	-	-
Hidalgo	1	-	-	-	-
Lea	17	3	4	23	-
Lincoln	8	1	1	8	-
Los Alamos	26	6	7	14	-
Luna	7	3	3	8	-
McKinley	43	7	10	35	-
Mora	-	-	-	-	-
Otero	25	6	7	26	-
Quay	5	-	-	4	-
Rio Arriba	24	1	5	12	-
Roosevelt	8	-	1	5	-
San Juan	69	22	17	72	-
San Miguel	23	1	6	18	-
Sandoval	60	6	4	22	-
Santa Fe	146	30	31	153	-
Sierra	6	1	-	3	-
Socorro	10	-	1	9	-
Taos	31	2	10	14	-
Torrance	1	1	-	-	-
Union	2	-	2	-	-
Valencia	21	-	-	5	-
Not Specified	27	7	6	33	39
Not NM*	42	27	28	199	-
Total	**1,450**	**446**	**437**	**1,792**	**40**
Adjusted for missing 12.6%	**1,633**	**502**	**492**	**2,018**	**45**

Source: New Mexico Center for Workforce Analysis at UNMHSC

* Not Specified means that the doctor does not have an identified practice county - such as a locum tenens

** 12.6% were not yet collected at the time of analysis and total is adjusted to more accurately reflect the number of doctors practicing in NM.

APPENDIX I: Predicted Levels of the Insured and Uninsured after ACA Implementation

Newly Eligible Medicaid Population	Exchange Population (~189,000 eligible for subsidies)	Remaining Uninsured Population
• HSD projects that 170 thousand New Mexicans, including the 38 thousand people currently enrolled in SCI, will become eligible for Medicaid under expansion. Of these, 137 thousand of the newly eligible will enroll in 2014 and 167 thousand will enroll by 2020. • Mathematica predicts that the newly eligible Medicaid population will include a mix of healthy and chronically ill; • Many of the first adults to enroll will likely those with the most significant health care needs • Mathematica also predicts that individuals who are below 50 percent of the FPL will have the highest levels of morbidity, including high rates of mental illness and substance abuse • States that have expanded coverage to low-income adults previously provide evidence about the likely healthcare needs and costs of the newly insured: • Oregon extended coverage to childless adults and found that the newly enrolled have greater healthcare utilization across all categories of service, including inpatient admissions, emergency room visits, and mental health/substance abuse services. • The newly eligible tended to use services most intensively during the month following coverage • Oregon found that the group most likely to enroll among the newly eligible was those with the lowest-incomes. These individuals tended to have more complex, chronic health needs than those close to the 133%FPL threshold • Maine expanded Medicaid coverage to adults up to 100% of the FPL and found that this population tended to have multiple, chronic health needs	• Currently uninsured New Mexicans who are ineligible for Medicaid. Exchange enrollment will be subsidized for New Mexican's with incomes below 400% of the FPL • The projected 2019 population is relatively older, less educated, lower income, and more racially diverse than the current privately-insured population (Kaiser). • Adults 19-64 account for 84% of projected enrollees, while the average age of enrollees is 35 • Males make up a slight majority of the Exchange population (52%) • Hispanics are predicted to account for 25% of the projected enrollees, while Whites will account for 58% • The majority of projected Exchange enrollees will transition from being previously uninsured (65%) and will demonstrate pent-up demand • Adults projected to enroll in the Exchanges report that they are in worse health but have fewer diagnosed chronic conditions than currently privately-insured populations • The Exchange population is much lower income than the projected non-Exchange population	• New Mexico's undocumented immigrant population will remain uninsured and continue to access care through the state's safety net system • The Pew Hispanic Center estimated New Mexico's undocumented population to be between 75 and 85 thousand in 2008 • Documented immigrants are eligible for Medicaid coverage after five years in the U.S. • The tax penalties may not be enough to induce adults to enroll in Medicaid or the Exchange; the penalty will only only apply to those with gross incomes above the income tax filing threshold ($9,350 for single filers under age 65 in 2009). In addition, the maximum penalty in 2014 will be only $95. • According to Kaiser, the projected population forgoing purchasing health insurance in the Exchange is of middle to upper-income and reports better health than the Exchange population. However, the eligible population projected not to enroll in the Exchange tends to have a lower income than individuals who are projected to purchase insurance in the non-Exchange non-group market. • Nationally, the Urban Institute predicts that 19 million Americans will remain uninsured after the implementation of the ACA • The Institute predicts that New Mexico's uninsured rate will decrease to 12% following the implementation of the ACA (~240 thousand people)

APPENDIX J: Additional Uninsured Groups

New Mexico is home to over 177 thousand veterans, 13 thousand of whom are uninsured veterans, representing 12.7 percent of the non-elderly veteran population. However, veterans are typically less likely than the rest of the non-elderly population to be uninsured. Nationally, one in 10 veterans under the age of 65 reported neither having health insurance coverage nor using the VA for healthcare needs. Approximately 900 thousand veterans in the United States use VA care but have no other health insurance coverage. These uninsured veterans tend to be younger, recently discharged, have lower levels of education, are less likely to be married and more likely to be unemployed than their insured counterparts. Forty-one percent of uninsured veterans report unmet medical needs, while 34 percent report having delayed care.

Veterans are eligible for VA healthcare and are not subject to the individual insurance mandate. To take advantage of their VA benefits, patients must receive care from an approved VA healthcare site. With the expansion of Medicaid in New Mexico, more veterans will now have insurance coverage and hence more choices in where they receive services. Like IHS, private insurance and Medicaid provide additional revenue for the VA.

The New Mexico Department of Health (DOH) reports a 2010 uninsured rate for Native Americans of 35 percent, approximately 72,800 people. Native Americans who are enrolled members of federally recognized tribes can receive free medical care from Indian Health Service (IHS) facilities or from tribal-run clinics organized under federal law.

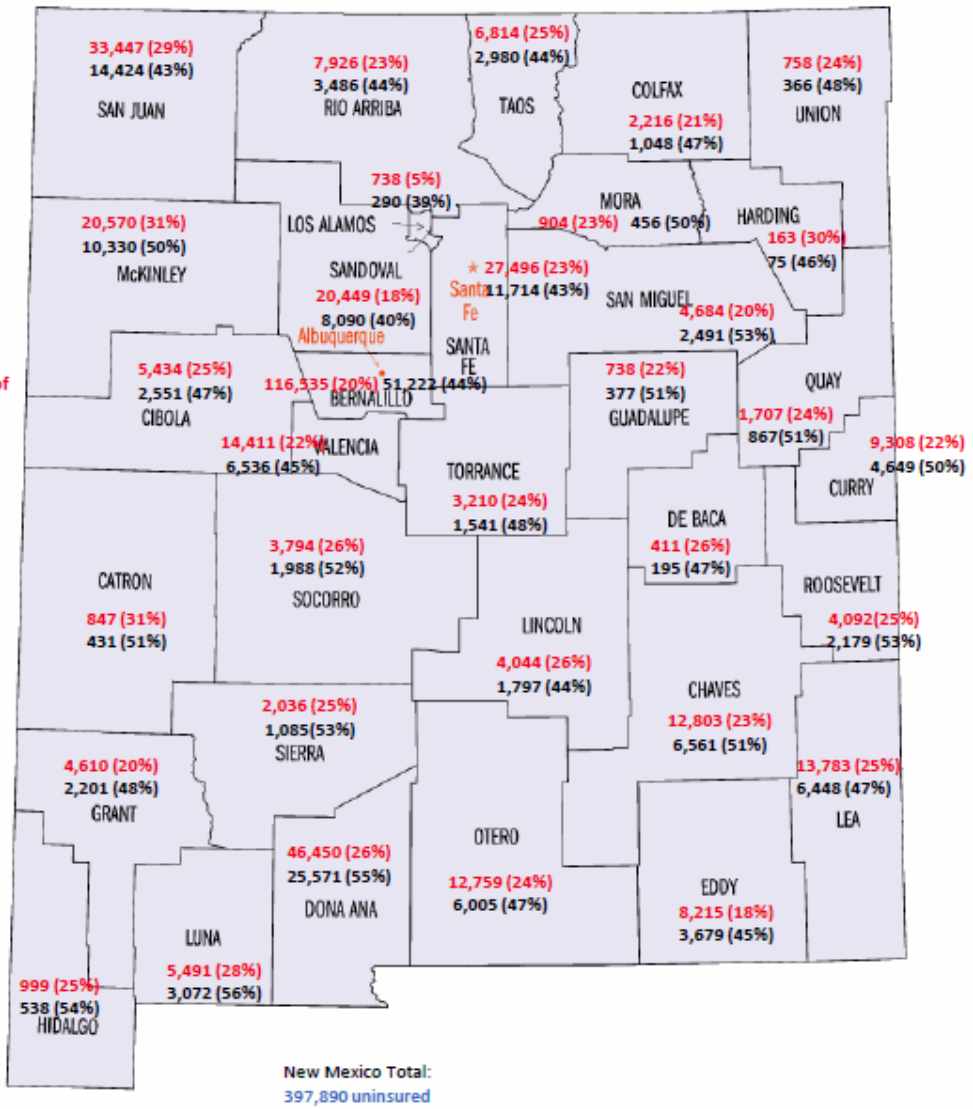
With the expansion of Medicaid, newly eligible tribal members will have additional choices as to where they receive health care. IHS providers and tribally-operated healthcare systems, which may receive Medicaid and private insurance reimbursement, will have additional sources of revenue as Native Americans seek coverage. However, Native Americans are exempt from the individual mandate to obtain insurance under the ACA and may instead choose to continue utilizing IHS services. Native Americans who are not eligible for Medicaid and choose not to purchase private insurance will still be considered uninsured, though they will not be subject to the individual mandate penalty, and may still be unable to access inpatient care or specialty services. Therefore, an uninsured Native American population will likely continue to exist after the implementation of the ACA and the expansion of Medicaid.

APPENDIX K: Health Care Preparation Offered by New Mexico's Public Institutions

	CCC	CNM	ENMU	LCC	NMHU	NMJC	NMSU	NNMC	SFCC	SJC	UNM	WMNU
Clinical Social Work (BSW+)			√		√		√					√
Counseling (Master's Level)			√		√		√				√	√
Dental Hygiene			√				√			√	√	
Medical School											√	
Occupational Therapy											√	
Pharmacy											√	
Physical Therapy											√	
PA											√	
Radiography	√	√	√				√	√			√	
Registered Nursing	√	√	√	√	√	√	√	√	√	√	√	√

Source: HED

Estimated Uninsured Population Under Age 65 by County



Source: U.S. Census Small Area Health Insurance Estimates, 2010