Report to
The LEGISLATIVE FINANCE COMMITTEE

Human Services Department and Taxation and Revenue Department
The Impact of Financing Healthcare through Tax Code Policy and Local Counties
December 6, 2011

Report #11-14

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David Abbey
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December 6, 2011

Ms. Sidonie Squier, Secretary
Human Services Department
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Santa Fe, NM 87505

Ms. Demesia Padilla, Secretary
Taxation and Revenue Department
1100 S. St. Francis Dr.
Santa Fe, NM 87505

Dear Secretary Squier and Secretary Padilla:

On behalf of the Legislative Finance Committee, I am pleased to transmit the *Impact of Financing Health Care through the Tax Code Policy and Local Counties.* The evaluation team assessed selected New Mexico healthcare tax expenditures as well as three locally-funded healthcare programs: The County Indigent Fund, the County Supported Medicaid Fund and the Sole Community Provider Hospital program.

An exit conference was conducted with the Human Services Department, the Taxation and Revenue Department and the Insurance Division of the Public Regulation Commission on October 14, 2011 to discuss the contents of this report. The first half of the report, dealing with healthcare tax expenditures, was presented to the LFC on October 21, 2011. We will present the second half, addressing locally-financed healthcare, on December 6, 2011.

I believe that 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: Senator John Arthur Smith, Chairman, Legislative Finance Committee
Representative Luciano "Lucky" Varela, Vice-Chairman, Legislative Finance Committee
Catherine Torres, M.D., Secretary, Department of Health
John G. Franchini, Superintendent of Insurance, Public Regulation Commission
Jerry Harrison, Ph.D., Chairman, New Mexico Health Policy Commission
Paul Gutierrez, Executive Director, New Mexico Association of Counties
Deborah Armstrong, Executive Director, New Mexico Medical Insurance Pool

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EXECUTIVE SUMMARY

Healthcare employment represents approximately 15 percent of the New Mexico workforce.

Healthcare will account for 24 percent of New Mexico's employment growth through 2019.

An estimated 92 percent of U.S. residents will be covered by healthcare insurance programs when national healthcare reform is fully implemented in 2019.

There will be an expected reduction in the uninsured of 32 million people and an increase in Medicaid coverage of about 16 million people by 2019 nationally.

U.S. healthcare spending is the highest among all industrialized nations and the rate of total U.S. healthcare spending has grown faster than inflation and the growth in national income. These healthcare expenditures surpassed $2.3 trillion in 2008.

The healthcare sector is also one of the fastest growing in the New Mexico economy. For FY12, estimated spending on healthcare will total over $4.5 billion through various state-run healthcare programs, including public employees. Expenditures for Medicaid alone are estimated to reach $3.7 billion in total funds, including $980 million from the general fund. For this reason, the LFC reviewed the impact of healthcare tax expenditures as well as locally-funded healthcare programs including the Sole Community Provider program.

Locally-financed healthcare programs in New Mexico represent a complex patchwork of programs intended to provide an indigent care safety net. Over $100 million is raised annually by counties to support county indigent programs, to participate in the funding of Medicaid programs, and to contribute to the support of Sole Community Provider hospitals. State and federal spending on the Sole Community Provider Program is projected to reach $267 million FY12. The program has grown exponentially over the years, with insufficient accountability and uncertainty as to its impact on increasing access to care or reducing uncompensated care.

Overall, New Mexico's healthcare tax expenditures account for an estimated $290 million in foregone revenue each year, but their true impact is difficult to measure. Most of these tax expenditures lack a clear purpose and there is not enough information collected from taxpayers to adequately gauge their impact on health policy. As a result, the state must rely on inconsistent forecasting to assess financial impact.

Some common themes permeate both the healthcare tax expenditure programs and the locally-financed healthcare programs. These programs are somewhat disjointed with insufficient accountability, unclearly defined goals and, in some cases, a diminished ongoing necessity after the implementation of national healthcare reform. In general, New Mexico needs to re-evaluate the use of local taxes to see if they are adequately addressing healthcare goals or if they need to be repurposed to better leverage federal matching funds.

KEY FINDINGS

Over $100 million is raised annually by counties to support county indigent programs, to participate in the funding of Medicaid programs and to contribute to the support of Sole Community Provider hospitals.

Counties contributed $23.5 million to the County-Supported Medicaid program in FY11.

It is unclear what impact of the Affordable Care Act will have on county indigent programs. In 2014, more individuals will have health insurance or will be eligible for Medicaid, so it is anticipated that few individuals will require at least primary care services.

SCP funding has grown from $55 million to $267 million since FY01 and continues to grow.

New Mexico's system of locally-financed healthcare is a complex patchwork of programs designed to provide an indigent care safety net. New Mexico counties play an important role in the funding of indigent healthcare programs throughout the state. In FY09, counties spent over $87 million on indigent healthcare. Funds are raised primarily through optional GRT increments dedicated to healthcare spending and, in some cases, through property tax support of local hospitals.

County indigent care programs are varied in their scope of coverage, eligibility requirements, and funding, which can create a disjointed indigent care system in New Mexico. County indigent care programs represent a way for counties to customize the provision of healthcare services to meet the unique needs of their communities. However, these funds are not eligible to draw down federal Medicaid match funds.

It is unclear whether some individuals covered under county indigent care programs might also be eligible for Medicaid. In those instances, the program cannot draw down federal match for those who are Medicaid eligible. In 2014, more individuals will have health insurance or will be eligible for Medicaid, so it is anticipated that fewer individuals will require county support through indigent care programs. The impact will vary depending on coverage rates by counties. With a diminished need, the question arises as to the need for this level of GRT support for indigent care programs in the future.

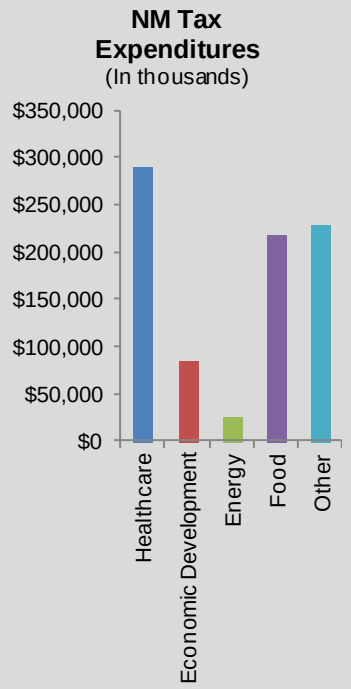
Counties contributed $23.5 million in FY11 to the County-Supported Medicaid program, without any feedback reporting on how a county's Medicaid population is being served by these funds. Counties are statutorily required to contribute to the state Medicaid program but do not receive any accountability reporting from the HSD to validate how these funds are used to provide coverage to citizens locally**.**

The Health Policy Commission databases are an important source of information regarding locally-financed healthcare programs. Much of the data regarding the local financing of healthcare services in New Mexico has been collected by the New Mexico Health Policy Commission. Funding for the Health Policy Commission has been discontinued while the mandate that this agency maintain three important databases remains in law.

Spending on the Sole Community Provider Program is projected to be $267 million with insufficient accountability and unclear future need. The Sole Community Provider (SCP) program is designed to provide supplemental Medicaid payments for hospitals that are the sole

New Mexico does not regularly assess the impact of the SCP funding on access to care or reducing uncompensated provider costs.

The need for the SCP program in its current form past 2014 needs to be examined.



Source: LFC

source of care for individuals in a designated area. Although this is not a mandatory program, the funding formula puts pressure on counties to provide the full match to available federal SCP funds. The SCP funding formula has contributed to average annual increased spending of about 20 percent between FY03 and FY10. In the unlikely event that counties are able to contribute the full match in FY12, the program could grow to $340 million.

The State and counties do not regularly assess the impact of SCP funding on access to healthcare, on reducing uncompensated care, or on the adequacy of Medicaid payments for hospital services. The program acknowledges that hospitals and hospital emergency rooms are often the care provider of last resort and that associated costs would require additional reimbursement. The SCP program takes into consideration under-compensated care for individuals on public assistance programs, such as Medicaid, and recognizes that, because of the rural nature of SCP hospitals, incentives are often required to attract qualified healthcare professionals. Many hospitals have come to depend on these SCP funds, however, based on available data from 2007, the program was more than offsetting these costs for the majority of SCP hospitals. Yet, neither the counties nor the HSD regularly assess the performance of this program.

The continuing need for the SCP program following national healthcare reform is questionable and warrants careful consideration. New Mexico has one of the highest uninsured rates in the nation and as more people have a source of payment for care, the continued need for SCP, particularly at current levels, will diminish beginning in 2014. In addition, issues have been raised concerning the financing of SCP, including whether certain provider donations to counties are permissible. A preliminary federal report has concluded that in certain instances the non-federal share of SCP payments in federal fiscal year 2009 were based on improper provider donations. A resolution is currently being negotiated that will hopefully mitigate the need to repay millions of dollars in federal funds.

New Mexico's Healthcare Tax Expenditures account for an estimated $290 million in foregone revenue, but their true impact is difficult to measure. New Mexico's healthcare tax expenditures lack a clearly defined purpose, adequate reporting requirements from taxpayers, and measurable outcome analysis. Of the five tax expenditures selected for review in this evaluation, only one had a specifically stated outcome goal, but none had ways to accurately measure the impact of the provision.

New Mexico's healthcare tax expenditures account for an estimated $290 million in foregone revenue each year, but their true impact is difficult to measure.

Of the five tax expenditures selected for review in this evaluation, only one had a specifically stated outcome goal, but none had ways to accurately measure the impact of the provision.

Insurers receive a substantial benefit from paying 4% tax on premiums instead of the state GRT rate of 5.125%.

Tax Expenditure	Foregone Revenue
Rural Healthcare Practitioner Tax Credit	$6.5 million
Hospital Credit for GRT	$12.5 million
Pre-emption for Those Subject to Premium Tax	$83.6 million
NMMIP Assessment Deduction	$49.6 million
Deduction for Medical Service Providers	$50 million

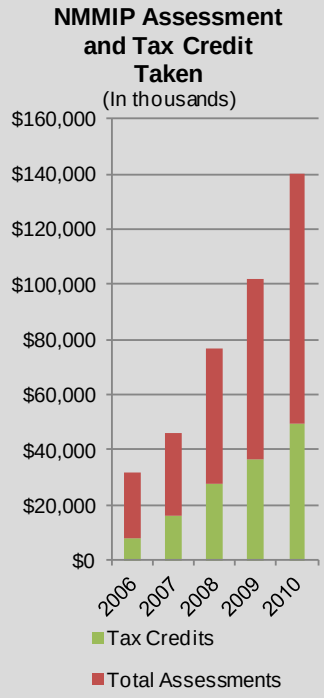
The TRD does not systematically collect data on existing tax expenditures, instead relying on forecasting to gauge impact. There are inconsistencies in the reporting of foregone revenue associated with tax expenditures, particularly the NMMIP Assessment Tax Deduction for Insurance Carriers and the Deduction for Medical Service Providers.

It is very difficult to determine if healthcare outcomes occur because of or in spite of the tax expenditure. Without good baseline and results data, the relationship is unclear between the programs in question and any changes in the target population.

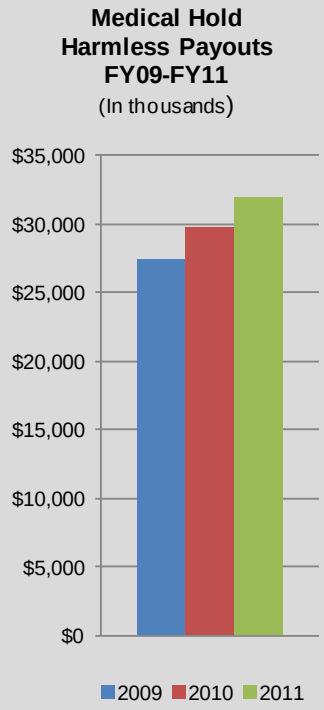
The Rural Healthcare Practitioner Tax Credit has a clear goal and is being utilized by rural healthcare providers, however its true impact is illusive. The Rural Healthcare Practitioner Tax Credit has a clear goal but evidence that it is achieving that goal is anecdotal. The tax credit program has grown much larger than originally expected, and because of this, the state has seen a much larger loss of tax revenue. Foregone revenue associated with this tax expenditure has reached an average maximum of $6.5 million per year. An accurate count of rural practitioners is not currently available since there is currently no mechanism for collecting information on the number of physicians practicing in rural areas – other than from the Rural Healthcare Practitioner Tax Credit program. However more licensed physicians have registered statewide since 2007.

The Hospital GRT Tax Credit results in for-profit hospitals paying zero state GRT by FY12, resulting in an estimated $12.5 million in foregone revenue growing to $14 million by FY15. No evidence is available to suggest that reducing the GRT liability of New Mexico for-profit hospitals has resulted in reduced costs to patients or insurance plans or has improved market share. Many hospitals operate in a limited competitive environment given the rural nature of the state.

The pre-emption of all other taxes for insurance companies subject to the premium tax results in a large amount of foregone revenue with unclear policy goals. Under the premium tax statute, health and life insurers pay 4 percent tax on gross premiums received from their insured in lieu of paying other taxes. The pre-emption of all other taxes for insurers created foregone GRT revenue for tax year 2010 of $83.6



Source: Leif Associates on behalf of NMMIP



Source: TRD

million alone. Estimates are not available for foregone corporate income tax, property taxes, or lost revenue from exempting taxation on other services provided by these companies. While the premium tax is high in comparison to other states, insurers still receive a substantial benefit from paying 4 percent tax on premiums instead of the state GRT rate of 5.125 percent, making New Mexico's premium tax more competitive when compared side by side to other state taxation policies for insurers.

The NMMIP Assessment Tax Deduction for insurance carriers accounted for $49.6 million in foregone revenue for tax year 2010, but will no longer be needed after national healthcare reform is implemented in 2014. All health and life insurers operating within the state of New Mexico are subject to paying an assessment fee to subsidize premiums paid into the New Mexico Medical Insurance Pool (NMMIP). Insurers subject to the NMMIP assessment are able to deduct 50 percent, and in some cases 75 percent, of total assessments paid off of their premium tax obligation. The NMMIP assessment accounted for $90 million in state revenue earmarked for a specific purpose in tax year 2010**.** These funds bypass the general appropriation process and are not subject to legislative scrutiny.

If NMMIP is no longer required as a result of healthcare reform, both the NMMIP assessment and the corresponding deduction should be addressed statutorily. The premium tax revenue that would be gained by eliminating the NMMIP tax deduction could potentially bring $49 million back into the general fund based on 2010 data.

The GRT tax deduction for medical service providers, coupled with a corresponding hold harmless for local governments, represents a double impact where the state is losing revenue through a tax expenditure and also a direct general fund expenditure to localities. The hold harmless distribution was created to offset local option GRT revenue losses. This deduction applies to providers who receive payments from any organized plan network, including HMO and PPO plans. Therefore, virtually all medical services are exempt from GRT. Total general fund impact for foregone GRT revenue plus hold harmless payouts to municipalities under the medical GRT repeal totaled $82 million for FY11. The state is losing the opportunity to appropriate hold harmless payments to federally matched programs which would have a greater impact on alleviating county healthcare burdens.

Key Recommendations

The Legislature should revise state law to move the responsibility for collecting and reporting of Health Policy Commission database information to another state agency such as the DOH, with a provision that researchers and policy experts at the University of New Mexico Health Sciences Center can access this information.

The HSD should develop guidelines for standardized SCP reporting by hospitals and should post reports on their website that show the full amount of SCP funding, both local and federal, by county, for the SCP program.

The HSD should develop a training module on locally-funded healthcare and make it available for use by the Association of Counties and individual counties.

The SCP funding formula should be revisited and changed to control exponential growth, and ensure total Medicaid payments do not exceed the costs of Medicaid and indigent care at specific hospitals.

The HSD, working with counties, should ensure local funding for SCP complies with federal regulations and provide a status report to the LFC no later than January 31, 2012 on resolution of outstanding issues stemming from the federal audit of SCP payments. The HSD should ensure that any possible repayment of funds does not impact the general fund.

No later than September 1, 2012, the HSD, working with counties and hospitals, should study and make recommendations to the LFC and governor whether SCP should continue with its current form and financing mechanisms given federal health reform and state Medicaid redesign.

The Legislature should work to phase out the hold harmless provision of the medical service providers deduction for GRT and redistribute these funds to federally-matchable healthcare programs as the need for local financing of healthcare diminishes.

The TRD should work to collect data on the financial impact of healthcare tax expenditures through a more detailed and transparent CRS form, rather than relying solely on forecasting.

Healthcare as part of the New Mexico economy. Each year, New Mexico spends an increasingly large portion of its available revenues on the provision of healthcare. For FY12, estimated spending on healthcare will total over $4.5 billion through various state-run healthcare programs, including public employees. Expenditures for Medicaid alone are estimated to reach $3.7 billion in all funds, with county and federal funding sources, including $980 million from the general fund.

The healthcare sector is one of the fastest growing of the New Mexico economy. At this time, healthcare employment represents approximately 15 percent of the workforce and the Department of Workforce Solutions estimates that this sector will account for 24 percent of employment growth through 2019.

Table 1. Top Five NM Industries by Percent Growth 2009-2019 Projected

Industry Title	Annual Avg. Percent Change	Total Percent Change
Health Care and Social Assistance	2.17%	23.90%
Other Services (Except Government)	1.25%	13.20%
Educational Services	1.18%	12.50%
Real Estate and Rental and Leasing	1.17%	12.40%
Accommodation and Food Services	1.17%	12.30%

Source: NMDWS Economic Research and Analysis Bureau

Nationally, healthcare spending accounts for 16 percent of U.S. gross domestic product. This is the highest among all industrialized nations, and the rate of total U.S. healthcare spending has grown faster than inflation and growth in national income. This rapid growth in spending, in combination with a significant economic downturn, has strained both public and private insurance.

National healthcare expenditures surpassed $2.3 trillion in 2008, more than three times the $714 billion spent in 1990 and over eight times the $253 billion spent in 1980. Medicare and Medicaid account for a large share of healthcare spending, but have increased at a slower rate than private insurance. Medicare per capita spending grew 6.8 percent annually between 1998 and 2008, versus 7.1 percent annual growth for private health insurance spending. Medicaid also grew at a slower rate than private spending, but this amount is planned to increase as more individuals become eligible. National healthcare reform is expected to be fully implemented by 2019. At that time, it is anticipated that 92 percent of U.S. residents will be covered by healthcare insurance programs, reducing the uninsured population by 32 million and increasing Medicaid coverage by an estimated 16 million people.

The federal Affordable Care Act (ACA), as it is currently envisioned, will play a significant role in the future of New Mexico's healthcare economics and service delivery. At a legislative hearing earlier this year, the HSD testified that by 2014, 130 thousand to 175 thousand more New Mexicans will be eligible for Medicaid through the Affordable Care Act. Even without the impact of the ACA, the state will see a 20 percent growth in Medicaid enrollment by 2019, according to the HSD.

Local Funding of Healthcare. Local governments also participate in the funding and provision of healthcare services in New Mexico. The Indigent Hospital and County Health Care Act provides the legal basis for much of this activity. This report addresses three specific healthcare funding programs: the County Indigent Care Fund (CIF), the Sole Community Provider Program (SCP) and the County-

Supported Medicaid Fund (CSMF). These programs primarily employ increments of gross receipts tax (GRT) or in some cases, property tax, as the mechanism for funding healthcare.

County Indigent Funds. The Indigent Hospital and County Health Care Act authorizes counties to pay for indigent healthcare claims by dedicating revenue from a second 1/8th increment to the GRT. Counties are statutorily required to report this activity to the Health Policy Commission. Thirty-one counties participate in this method of funding local indigent care. Counties may also choose to dedicate 50 percent of an optional 3rd 1/8th GRT increment to the CIF. Bernalillo County is a statutory exception, in that it contributes a flat $1 million per year to its indigent care fund, which is directly distributed to University of New Mexico Hospital. Counties may use other sources of funding as well, including the sale of property, mill levy taxes, investment income and grants. Each county independently determines eligibility for services, what services are offered, the allocation of funds and the approval of claims. In FY09, 31 counties spent $87 million through the CIF. Below are some key facts about county indigent funds:

- The counties decide how these funds are to be used for indigent healthcare.
- It is not mandatory for the county to impose these taxes. If they do, they must be dedicated to indigent care.
- Revenue in the indigent care fund cannot be matched by federal dollars.
- Funds must be used for purposes specified in the Indigent Hospital and County Health Care Act. This may include transfers to the Sole Community Provider program to meet matching requirements (i.e., once the funds are transferred into the SCP fund they can be matched).
- These funds may also be transferred to the County-Supported Medicaid Fund to meet the 1/16th requirement.

County-Supported Medicaid. The County-Supported Medicaid Fund is a mandatory program in which counties provide funding to the state to draw down federal matching dollars for Medicaid. Counties may use a separate 1/16th GRT increment for this purpose, or may provide an equivalent amount of funding from any existing authorized county revenue source. In FY11, New Mexico counties contributed $23.5 million. Nine percent of these funds are directed through the state's Rural Primary Health Care Act to the DOH fund to support primary care clinics. Three percent is directed to DOH administration.

Sole Community Provider Program. The Indigent Hospital and County Health Care Act also established the Sole Community Provider Program (SCP), a federal/state payment program administered by the Human Services Department (HSD), matching county funds with federal dollars. The program is designed to provide higher funding and a supplemental payment program for hospitals that are the sole source of care for individuals in a designated area. The maximum funding is based on the HSD calculation that includes the prior year base plus the prior year supplemental payment plus an inflation factor. All New Mexico acute care hospitals, except for hospitals in Albuquerque, participate in the SCP program. Counties use hospital mill levies or other funds, including the County Indigent Care Fund, to support this program. Qualified hospitals are also eligible for a related Upper Payment Limit (UPL) Program payment, which may be paid to a hospital later in the year. Key elements of the program include:

- This is not a mandatory program – counties may choose not to participate.
- The Human Services Department receives these funds from counties and draws down a federal match.

- Most counties transfer funds from their County Indigent Care Fund to support the SCP.

Tax Expenditures. In addition to direct expenditures, New Mexico contributes a significant amount of revenue through healthcare tax expenditures. Tax expenditures, in the form of tax credits, deductions, exclusions, exemptions and deferrals, often play an important role in public policy goals. On the other hand, tax expenditures often have unclear goals resulting in government's inability to accurately measure their impact. Since anyone who meets the statutory eligibility requirements can take a tax credit, deduction, or exemption, they function similarly to entitlement spending and can only be changed through legislative action. The TRD estimated that in FY13, all of New Mexico's tax expenditures will result in over $922 million in foregone revenue.

Table 2. New Mexico Major Tax Expenditures
(in millions)

Target of Tax Expenditures	Number of Provisions	Estimated FY12 General Fund Impact
Economic Development	20	($84.6)
Poverty, Health, Education	30	($367.5)
Renewable Energy	13	($24.8)
All Other	36	($445.9)
Total	**99**	**($922.8)**

Source: LFC, TRD

There are almost twenty tax expenditures related to healthcare, and an estimated $290 million annually in foregone revenue can be attributed to these healthcare tax expenditures. These expenditures are typically intended to reinforce health policy goals such as increasing access to healthcare services, recruiting and retaining healthcare professionals, or encouraging health-related companies to do business in New Mexico. The overriding question with healthcare tax expenditures centers on whether or not New Mexico could better utilize this foregone revenue through direct appropriations, and whether sufficient accountability exists for these tax expenditures.

Table 3. New Mexico Tax Preferences for Healthcare

Statute	Adopted	Tax	Description	Foregone Revenue* (millions)
7-2-5.6	1995	PIT	Medical savings accounts exemption	$0.2
7-2-5.9; 7-2-18.13	2005	PIT	Over 65 uncompensated medical care exemption	$0.2
7-2-18.22	***2007***	***PIT***	***Rural healthcare practitioner credit***	*****$6.7***
7-2-35	2000	PIT	Uncompensated care exemption (Low Income)	$3.5
7-2-36	2005	PIT	Organ donation expense deduction	$0.1
7-9-73	1970	GRT	Prosthetic devise deduction	$1.0
7-9-73.1	1993	GRT	50% hospital receipts deduction	$20.0
7-9-73.2	1998	GRT	Prescription drugs deduction	$35.0
7-9-77.1	1998	GRT	Medicare medical services deduction	$22.0
7-9-93	***2004***	***GRT***	***Medical Service Provider Deduction***	***$50.0***
7-9-96.1	***2007***	***GRT***	***Hospital GRT credit***	***$12.5***
7-9-16	1970	GRT	Non profit nursing home exemption	$1.0
7-9-96.2	2007	GRT	Unreimbursed service credit	$2.0
7-9-99; 100	2006	GRT	Hospital construction deduction	$0.7
7-9-111	2007	GRT	Hearing and vision aids deduction	$1.6
59A-54-10	***1978***	***Ins. Premium***	***NMMIP assessment deduction***	******49.6***
59fA-6-6; 7-9-24	***1969***	***CIT. GRT***	***Other tax pre-emption for health and life insurers***	***$83.6***
				$289.5

* Foregone Revenue estimated for FY13

Source: LFC

** Maximum Potential Foregone Revenue

*** Based on 2010 actuals

The evaluation examined five New Mexico tax expenditures, based on size or potential impact of the expenditure, to determine how effective they are in meeting healthcare goals. The tax expenditures include the following:

- Rural Healthcare Practitioner Credit
- Hospital-Related GRT Tax Expenditures
- Pre-emption of all other taxes for insurance companies subject to Premiums Tax
- NMMIP Assessment Tax Deduction for Insurance Carriers
- Medical Service Provider Deduction

EVALUATION INFORMATION:

Evaluation Objectives.

- Determine if current healthcare tax expenditures achieve their intended outcomes.
- Determine if locally-funded healthcare programs meet public policy goals.
- Assess the financial impact of healthcare tax expenditures and locally-funded healthcare programs on the state.
- Determine what impact healthcare reform will have on these programs.

Scope and Methodology.

- Reviewed:
  - Applicable laws and regulations;
  - LFC file documents, including all available project documents;
  - Relevant benchmarks, policy, and procedures from other states;
  - Information from outside sources including HPC and CMS;
  - Agency policy and procedures regarding tax expenditures and locally-financed healthcare programs;
- Interviewed state agency staff, county staff, and industry association staff.
- Tax expenditures were evaluated using the following framework:
  - Description
  - Goal
  - Issues or Concerns
  - Foregone revenue impact
  - Legislation and law
  - Eligibility and certification requirements
  - Impact on target population or program
  - Other factors that may have influenced the change – possible alternative policies
  - Number of persons taking advantage of the credit, deduction, etc.

This framework includes many of the evaluation criteria outlined by the New Mexico Taxation and Revenue Department in discussing their upcoming comprehensive tax expenditure analysis – as presented to the LFC in August 2011.

Authority for Evaluation. The LFC has the statutory authority under 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. The LFC is also authorized to make recommendations for change to the Legislature. In furtherance of its statutory responsibility, the LFC may conduct inquiries into specific transactions affecting the operating policies and cost of governmental units and their compliance with state law.

Evaluation Team.

Charles Sallee, Deputy Director for Program Evaluation
Jack Evans, Lead Evaluator
Maria D. Griego, Program Evaluator

Exit Conference. The contents of this report were discussed with Human Services Department Secretary Squier, Tax and Revenue Department Secretary Padilla, and Insurance Superintendent John Franchini on October 14, 2011.

Report Distribution. This report is intended for the information of the Human Services Department, the Taxation and Revenue Department, the 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

NEW MEXICO'S LOCALLY-FINANCED HEALTHCARE SYSTEM IS A COMPLEX PATCHWORK OF PROGRAMS DESIGNED TO PROVIDE AN INDIGENT CARE SAFETY NET

New Mexico counties play an important role in the funding of indigent healthcare programs throughout the state. In FY09, counties spent over $87 million on indigent healthcare. Funds are raised primarily through optional GRT increments dedicated to healthcare spending and, in some cases, through property tax support of local hospitals. The Indigent Hospital and County Health Care Act provides the legal basis for three indigent healthcare programs: the County Indigent Care Fund (CIF), the Sole Community Provider Program (SCP) and the County-Supported Medicaid Fund (CSMF). The Sole Community Provider program has two components: an annual base payment and a subsequent upper payment limit supplemental payment. See **Appendix A** for a table summarizing the sources and uses of funds for these programs. By statute, the New Mexico Health Policy Commission (HPC) collects data on locally-financed healthcare programs.

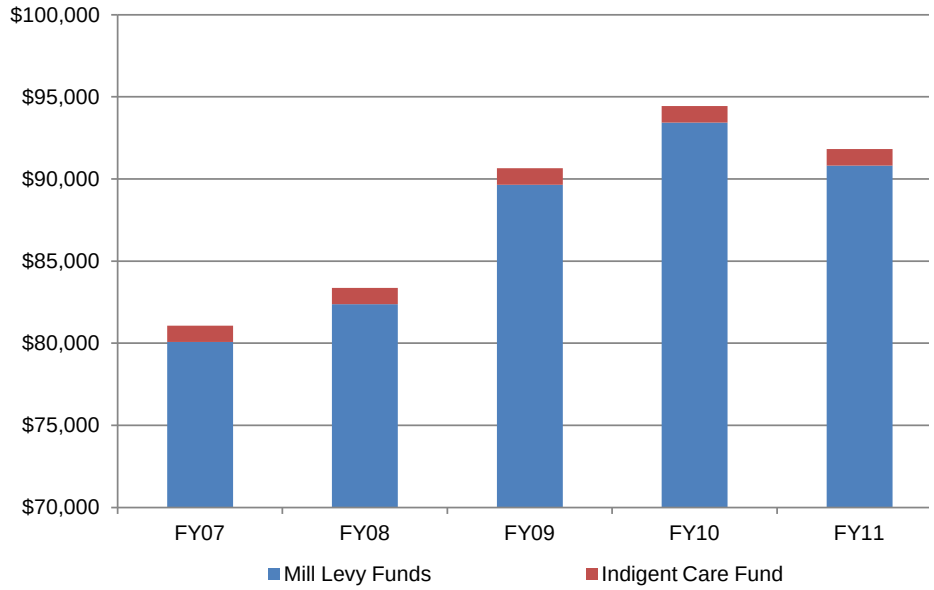
County indigent care programs vary in their scope of coverage, eligibility requirements, and funding, creating a disjointed indigent care system in New Mexico. County indigent care programs represent a way for counties to customize the provision of healthcare services to meet the unique needs of their communities. Counties use various models to manage their programs, and eligibility requirements vary by county. The majority of counties that have programs use GRT increments for funding, while the remainder either use mill levy funds or a combination of GRT and mill levy. Counties completely control their indigent funds and programs. The counties consider this flexibility a strength, in that it allows county commissioners to be more directly involved in program design, allows counties to tailor their programs to the special community needs and provides the opportunity to develop strong provider networks. On the other hand, the dollars are not leveraged by Medicaid.

It is unclear whether some individuals covered under county indigent care programs might also be eligible for Medicaid. In those instances, the program would not effectively leverage federal match for those who are Medicaid eligible. In any case, county indigent care programs will most likely have a vastly reduced role when most individuals are covered by Medicaid or some type of private insurance under federal healthcare reform. With a diminished need, requirements for this level of GRT support for indigent care programs may decrease.

County indigent programs vary in their focus, plan design, and eligibility requirements. Doña Ana County's indigent care program has emerged as a best practice, with the goal to manage patient care. When an indigent patient is hospitalized, the county places the patient in a medical home model, where primary care and preventive medicine are emphasized. In Santa Fe County, once applicants pass the county's eligibility requirements, they can go to a program-approved provider and the claim is paid by the county's indigent fund. In Sandoval County, eligible recipients receive a set amount of dollars per service category. For example, the county aims to reduce excessive use of emergency room care by not covering this service, but instead covering in-patient hospital care up to an annual maximum. Additionally, county indigent care programs are also fragmented in their eligibility requirements.

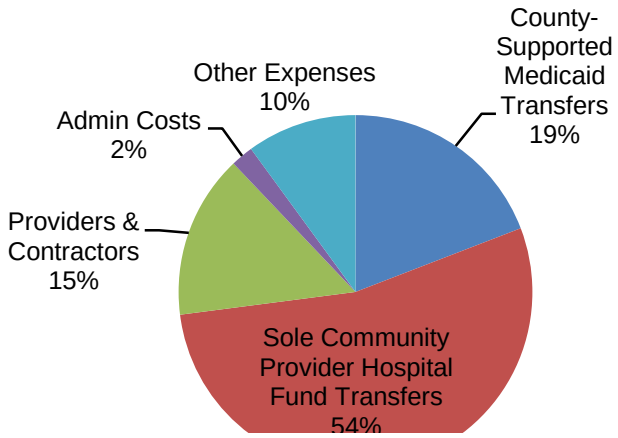
Bernalillo County is unique in focusing the majority of indigent funds to UNM Hospital. Bernalillo County enacted a mill levy to support indigent care at UNM Hospital (UNMH), which in FY11 totaled $91 million. The mill levy is written for the general maintenance and operations of the hospital, and does not speak specifically to indigent care. UNMH does not provide claims level data to Bernalillo County on uses of mill levy funds. Additionally, the county takes $1 million out of its 2nd 1/8th GRT increment for healthcare to also support UNMH's indigent care function.

Graph 1. Bernalillo County Indigent Care Mill Levy and Other Indigent Care Funds
(In thousands)



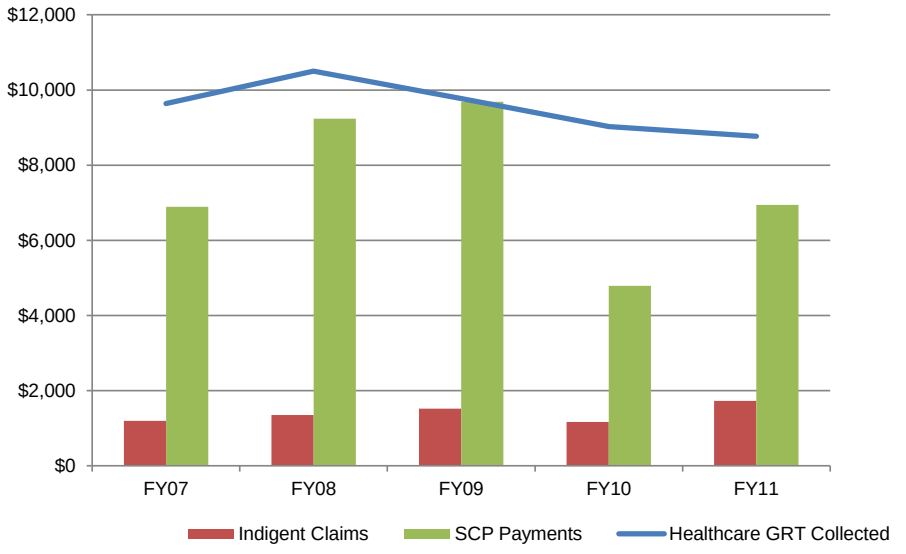
Indigent program funding is compromised by declining GRT revenues. Indigent care programs are funded through the statutorily-designated 2nd and 3rd 1/8th GRT increments, therefore negative changes to GRT revenue directly impact funds available to provide indigent care for the majority of New Mexico's counties. For example, San Juan County's 2nd 1/8th GRT increment for healthcare was $4.4 million for FY11, while indigent claim costs were $2.1 million, a growth rate of 1 percent and 13 percent respectively from FY10. If care costs continue to outpace GRT revenue growth, GRT alone will not be able to fund indigent care.

Graph 2. FY09 County Indigent Fund Expenditures



Growing obligations to the Sole Community Provider (SCP) program minimize funds available for indigent care. As the funding formula for SCP continues to grow exponentially, residual funds for other county healthcare programs are reduced. Counties use indigent care funds for everything from indigent care claims to funding preventive care clinics, county inmate healthcare, and detox and sobering centers. According to a 2004 Commonwealth Fund study, "Reducing preventable hospitalizations can preserve healthcare dollars to help fund improvements in ambulatory care. For example, assuming that an average hospital stay costs $5,300 per admission, even a modest 5 percent decrease in hospitalizations for these ambulatory care-sensitive conditions would save more than $1.3 billion in inpatient costs" (Kruzikas et al. 2004). Putting more county dollars towards preventive and primary care reduces the burden on county hospitals, but counties do not have the resources to further invest in these programs and continue to fund the SCP program at its current growth rate.

Graph 3. Santa Fe County Healthcare GRT Collection and Indigent Care Spending
(In thousands)



Note: FY10 is after ARRA funds were deducted.

Source: Santa Fe County

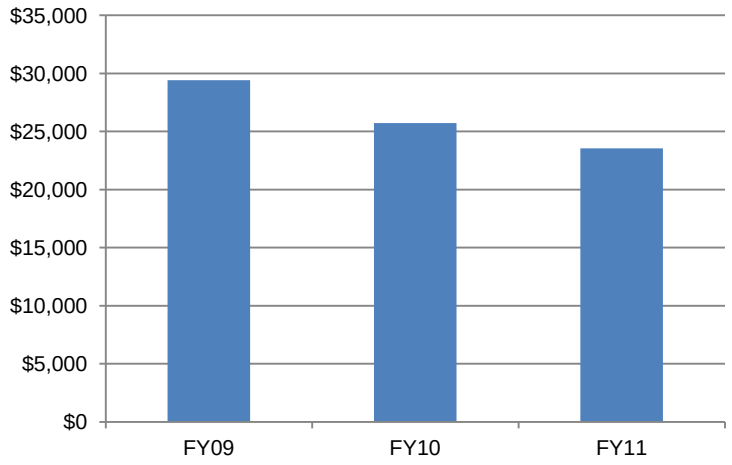
It is unclear what impact the Affordable Care Act will have on county indigent programs. When the ACA is implemented in 2014, more individuals will have health insurance or will be eligible for Medicaid, so it is anticipated that fewer individuals will require at least primary care services. However, there will still be a need for programs, such as ambulance services, that are not covered under the ACA. The status of undocumented immigrants, who are not eligible for Medicaid or for participation in an insurance exchange, is also an issue under the ACA.

Counties contributed $23.5 million in FY11 to the County-Supported Medicaid program, without any feedback reporting on how these funds serve a county's Medicaid population. Counties are statutorily required to either enact a 1/16th GRT increment or pay the equivalent through other revenue sources to support the Medicaid program in New Mexico. The TRD collects funds for those counties who enacted the GRT increment, and the HSD bills counties who are satisfying this obligation through other revenues.

The economic downturn and lower county GRT revenues have negatively impacted County-Supported Medicaid funding, resulting in a greater need for state general fund to offset this deficit. The County Indigent Care Act stipulates that 1/16th of county GRT revenues go to support the state Medicaid program. As a result of the recent economic downturn, consumer spending has declined, causing GRT revenues to follow suit. As a function of this same trend, the GRT revenue available to support the 1/16th mandate for County-Supported Medicaid has also been shrinking. For example, Santa Fe County had GRT revenues of $42.2 million in 2010, and contributed $2.03 million to the CSMF. However, in 2011, GRT revenues dropped to $41.4 million, and therefore CSMF funding also dropped to $2 million.

Counties are statutorily required to contribute to the state Medicaid program but do not receive consistent reporting from the HSD to validate how these funds are used. County funds go into the overall balance of state funds to support state Medicaid programs. At this point, counties lose visibility as to how funds are disbursed and used. Therefore, counties cannot assess the effectiveness of these funds in supporting Medicaid recipients residing in their counties. Counties also do not receive data showing how many Medicaid recipients reside in their county, although the HSD does makes this data available on their website with a four month lag. Counties are unable to identify what they are buying for their constituents with county-supported Medicaid dollars. While not statutorily required, it would be beneficial for the state to provide county-specific information to counties benefitting from County-Supported Medicaid funding. By making more information available, the HSD would foster a stronger working relationship with counties. **Appendix G** lists Medicaid funding provided by counties.

Graph 4. County-Supported Medicaid Funding
(In thousands)



Source: HSD

The Health Policy Commission Databases are an important source of information regarding locally-financed healthcare programs. The New Mexico Health Policy Commission collects much of the data regarding the local financing of healthcare services in New Mexico. The HPC has responsibility for three databases:

The Hospital Discharge Database (HIDD),
The Geographic Access Data System (GADS), and
The County-Based Financing of Health Care Database (CIF).

Funding for the Health Policy Commission has been discontinued while statute mandates that this agency maintain three important databases. An MOU was put in place between the Department of Health (DOH) and the HPC, but parts of it are no longer functional because of loss of budget and staff. Currently, only the HIDD database may be used by the DOH. Restrictions remain, such as on the release of information. These restrictions on the use of data may not meet requirements of healthcare reform for the state's purposes.

These databases face the threat of disappearance unless changes are made to the statute covering the HPC. At this time, data is accumulating to these databases but the HPC does not have the funding to continue reporting. The DOH does have access to the HIDD database because restrictions remain on the release of information. No one other than the HPC has the authority to release this information. The last reports from these databases cover the year 2009. Statutory change is needed to transfer the responsibility for collection and reporting of this information to another state agency, such as the DOH.

RECOMMENDATIONS

The HSD should continue to make available on its website a County-Supported Medicaid Fund report showing Medicaid enrollment in each county. Information should also be included regarding Medicaid expenditures in each county.

The Legislature should redefine the uses of the 2nd and 3rd 1/8th GRT increments under the County Indigent Care Act, allowing counties to determine other uses for these funds as healthcare will move more under state jurisdiction due to healthcare reform and local financing of healthcare programs will diminish.

The Legislature should revise statute to move the responsibility for collecting and reporting of Health Policy Commission database information to another state agency such as the DOH.

The Legislature should revise statute to allow researchers and policy experts at the University of New Mexico Health Sciences Center to have access to HPC database data.

SPENDING ON THE SOLE COMMUNITY PROVIDER PROGRAM IS PROJECTED TO BE $267 MILLION WITH INSUFFICIENT ACCOUNTABILITY AND UNCLEAR FUTURE NEED

The Sole Community Provider program (SCP) is designed to provide supplemental Medicaid payments for hospitals that are the sole source of care for individuals in a designated area. In 1994, the Indigent Hospital and County Health Care Act established the SCP, a federal/state/local payment program administered by the Human Services Department (HSD) that uses county funds to match federal Medicaid dollars. The SCP program was initiated as a way to maximize indigent care funding for hospitals.

The HSD has stressed that the purpose of the SCP program is broader than indigent care. The program acknowledges that hospitals and hospital emergency rooms were often the care provider of last resort and that costs associated with that situation would require additional reimbursement. The SCP program takes into consideration under-compensated care for individuals on public assistance programs and recognizes that because of the rural nature of SCP hospitals, incentives are often required to attract qualified healthcare professionals.

Similar to other hospital-based supplemental payment programs through Medicaid and Medicare, the underlying assumption is that a sole rural provider will have unreimbursed expenses because of scale inefficiencies, limited means to cost-shift for indigent patients, and hospital emergency rooms are often the healthcare provider of last resort, albeit an expensive one. Qualified hospitals are also eligible for a related upper payment limit (UPL) program intended to close the gap between the differences in rates paid by Medicaid versus Medicare. As a result, additional federal dollars are made available to these facilities so that they can continue to provide a critical healthcare service and to promote access to Medicare and Medicaid beneficiaries. The program operates under the state's federally approved Medicaid state plan.

Some counties and communities have more than one hospital participating in the sole community provider program. The criteria for an SCP hospital include the requirement that it be located more than 35 miles from other similar hospitals. Las Cruces and Roswell each have two hospitals receiving SCP payments, as do Eddy and Lea Counties. Santa Fe has one SCP participating hospital, though citizens have had access to another small physician-owned hospital. The SCP program has 28 hospitals participating, and the University of New Mexico Hospital qualifies for the related upper payment limit program. As a result, almost all New Mexico acute care hospitals, except for hospitals in Albuquerque, participate in the SCP program.

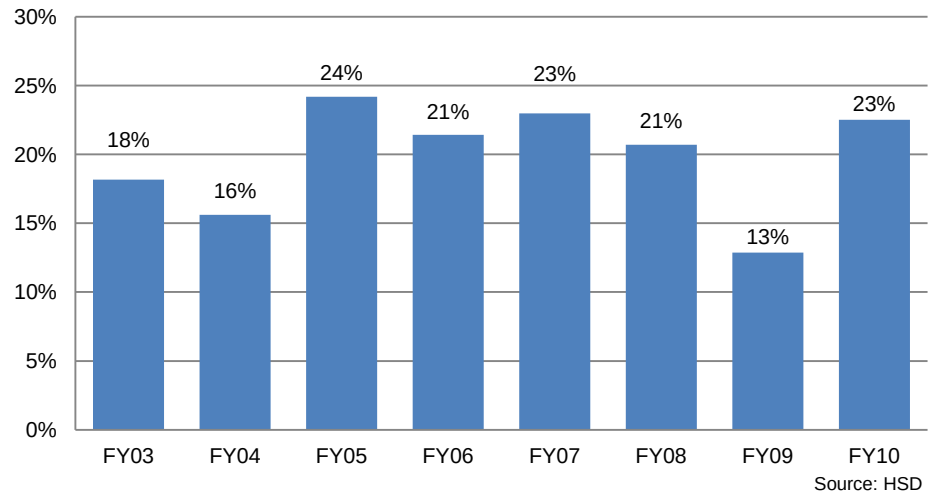
An exception to location criteria was made in 2001 via a waiver from the federal Centers for Medicare and Medicaid Services (CMS) and accompanying state legislation. Through these measures, the state amended its definition of sole community provider to ensure that existing Las Cruces and Santa Fe hospitals remained eligible for SCP funding regardless of whether a second facility were built in those communities. As a result of this amendment, both Mountain View Regional and Memorial Hospital in Doña Ana County receive SCP payments, even though they are less than 35 miles apart.

The SCP funding formula results in potentially unsustainable growth; projected spending could reach $267 million in FY12, up from $55 million in FY01. According to the HSD, the total available funding for SCP would be $340 million in FY12 based on the SCP formula. However, counties are not expected to fully fund SCP, bringing projected spending down almost $73 million to $267 million

according to the HSD's latest Medicaid projection. Counties primarily use money from the County Indigent Care Fund to meet the matching requirements, but can, and do, also use hospital mill levies or other general funds to support this program. However, the vast majority of the local match comes from the County Indigent Care Fund. For FY12, the HSD estimated that the state would not draw down $52 million in available federal funds.

The SCP funding formula has contributed to average annual increased spending of about 20 percent between FY03 and FY10. The SCP is not a mandatory program and counties have complete discretion in how much to allocate for this locally-financed healthcare program. Each year, HSD calculates the maximum amount allowed for each hospital using the federally approved SCP funding formula. To determine the current year base funding amount, HSD includes the previous year's base funding plus the previous year's supplemental funding plus a market basket factor (an inflation factor that is typically 2 to 3 percent). The amount available for hospitals is based on the lesser of the amount approved from counties or the state's calculation. Each year the supplemental funding amount is rolled into the base funding amount, plus an inflation factor and a new base amount is identified.

Graph 5. Percent Increase in Total SCP Funding



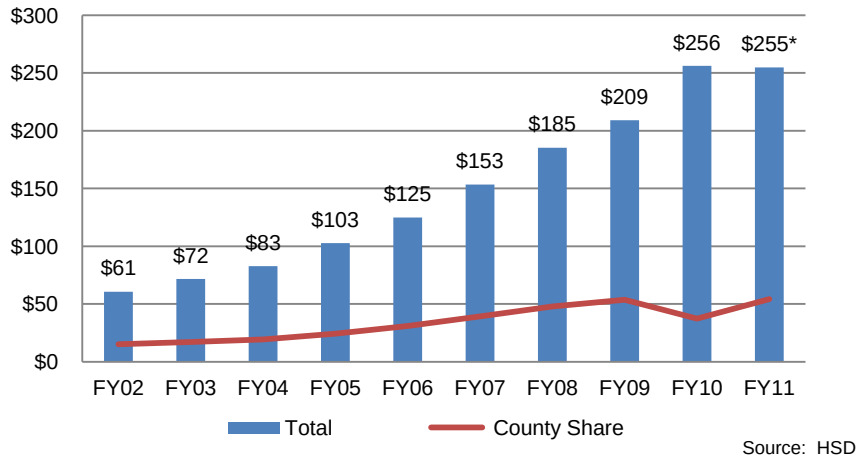
Source: HSD

As a result of this formula, counties often feel pressured to increase their contribution to fully match available SCP funds causing their contributions to grow over the years. For most of the past decade county GRT revenues and contributions kept up with this growth rate, though SCP has taken a larger share of indigent funding. Between FY02 and FY09, counties' SCP contributions increased 250 percent, from $15.1 million to over $53 million. During this same period year-end balances in County Indigent Care Funds, the primary source of funding for SCP, increased from $9.9 million to more than $29 million. Transfers from the Indigent Care Fund accounted for about 87 percent of the counties' match, or $46.9 million. During that same year, these SCP payments accounted for 54 percent of County Indigent Care Fund expenses, up 17 percent from $4.2 million in FY99.

The continued rapid increases in available SCP funding indirectly pressured counties to put up the full matching funds, in some cases at the expense of other local programs. Regulations state hospitals will receive the lesser of the county approved amount or the HSD calculation. Counties are not under a mandate to provide the maximum match, but can receive considerable pressure from hospitals to provide

the full amount. For example, in one community the local hospital paid for a full-page advertisement calling for county support for full SCP funding. Like the state, counties' revenue decreased rapidly during the recent recession, though SCP also benefitted from an enhanced federal matching rate because of the American Recovery and Reinvestment Act.

Graph 6. Sole Community Provider Program Spending
(In millions)



Source: HSD
Note: County share decreased in FY09-FY10 due to AARA.
* Estimated assuming the expected drawdown of federal revenue

The State and the counties do not regularly assess the impact of SCP funding on access to healthcare, on reducing uncompensated care, or on the adequacy of Medicaid payments for hospital services. Each year, increasing amounts are spent on SCP to support hospitals caring for indigent New Mexicans and to supplement basic Medicaid payments.

SCP reporting from hospitals is often inadequate and lacks standardization statewide. Many hospitals do not report the number of county patients served by SCP funds and whether or not these patients are Medicaid eligible, though some do. Statute requires counties to negotiate a reporting format with SCP hospitals. However, this varies widely and often does not appear to comply with the statute. Several counties would like to have this information for their constituents and boards to support the securing of county funds for the SCP program, while some, like San Juan County, appear to receive sufficient information for decision-making.

A standardized county commission education program on locally-financed healthcare is needed to fully inform policy decisions. A significant number of county commissioners turn over each year. The SCP program is quite complex and can have major financial consequences for counties and for local hospitals. HSD presents information on SCP program operations to county officials and hospitals administrators, but a more systematic, standardized training for counties and hospitals regarding this important program should be developed.

The SCP program does not specify how funds are to be used by hospitals and lacks an assessment of whether Medicaid and indigent uncompensated care costs are reduced. SCP is not the only Medicaid program intended to help offset uncompensated care costs from indigent patients or low Medicaid

payments. State Medicaid programs are required by federal law to consider hospitals that serve a disproportionate number of low-income patients when determining in-patient payment rates.

In New Mexico, as of 2007, almost half of the hospitals receiving Sole Community Provider funding also received funding through the Medicaid Disproportionate Share (DSH) program. The HSD uses a special formula that takes into consideration each hospital's Medicaid inpatient utilization rate, its low-income utilization rate, the amount of Medicaid funds it received, the total cost of care for Medicaid services, its uncompensated care, as well as other factors, to determine the Medicaid DSH payment. As of 2007, 19 of 23 DSH hospitals received a higher total Medicaid reimbursement than their total cost of care for Medicaid services. The excess Medicaid payments, including SCP, eliminated total unreimbursed, uncompensated care costs and resulted in a net gain to these hospitals totaling $46.2 million. For three hospitals, the excess Medicaid payments did not result in positive net revenue. The DSH reporting format could serve as a useful template for an ongoing assessment of the role of not only DSH, SCP, and other Medicaid payment levels, in covering Medicaid, as well as indigent and uncompensated care costs.

Table 4. Impact of Medicaid Payments on Hospitals Receiving Both SCP and Disproportionate Share Supplemental Payments - FY07

Hospital Name	Grand Total Medicaid Payments*	Total Cost of Care - Medicaid	Medicaid Net Gain (Loss)	Total Uninsured Uncompensated Care Costs**	Total Net Gain (Loss) from Medicaid and Uninsured Uncompensated Care Costs^
Alta Vista Regional Hospital	$11,714,617	($9,197,320)	$2,517,297	($1,528,726)	$988,571
Carlsbad Medical Center	$14,026,426	($7,370,073)	$6,656,353	($2,158,728)	$4,497,625
Cibola General Hospital	$4,423,457	($1,626,929)	$2,796,528	$0	$2,796,528
Eastern New Mexico Medical Center	$27,171,299	($21,428,052)	$5,743,247	($5,193,864)	$549,383
Espanola Hospital	$13,000,618	($6,160,526)	$6,840,092	($4,207,475)	$2,632,617
Holy Cross Hospital	$10,233,264	($12,990,853)	($2,757,589)	($3,623,843)	($6,381,432)
Lea Regional Hospital	$16,436,659	($15,763,697)	$672,962	($3,443,114)	($2,770,152)
Lincoln County Medical Center	$6,582,933	($3,050,615)	$3,532,318	($1,798,977)	$1,733,341
Memorial Medical Center	$34,432,030	($5,788,092)	$28,643,938	$726,630	$29,370,568
Mimbres Memorial Hospital	$9,190,663	($3,597,057)	$5,593,606	($995,397)	$4,598,209
Plains Regional Medical Center - Clovis	$20,451,321	($11,478,683)	$8,972,638	($3,826,197)	$5,146,441
Rehoboth McKinley Christian Health Care Services	$2,582,411	($1,958,392)	$624,019	($182,711)	$441,308
Roosevelt General Hospital	$1,228,973	($656,181)	$572,792	$757,742	$1,330,534
Socorro General Hospital	$6,453,292	($3,791,512)	$2,661,780	($1,260,872)	$1,400,908
St. Vincent Hospital	$50,202,345	($36,516,109)	$13,686,236	($14,492,139)	($805,903)
Union County General Hospital	$1,618,933	($419,162)	$1,199,771	($493,646)	$706,125
Total	$229,749,241	($141,793,253)	$87,955,988	($41,721,317)	$46,234,671

Source: HSD Annual DSH Report FY07. https://www.cms.gov/MedicaidRF/Downloads/SPRY007.zip

*Medicaid payments include inpatient/outpatient fee-for-service and managed care, supplemental payments, including SCP and DSH.

**Net uninsured uncompensated care costs after indigent care/patient self-pay and Section 1011 revenue.

^ According to HSD, "The definition of uncompensated care was based on guidance published by CMS in the final rule (73 Fed. Reg. 77904, December 19, 2008). The calculated uncompensated care costs (UCC) represent the net uncompensated costs of providing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage."

Note: Some hospitals that received DSH payments did not receive SCP funding, such as the University of New Mexico Hospital – which received almost 80 percent of total DSH funding.

Issues have been raised concerning the financing of SCP, including whether certain provider donations to counties are permissible. SCP is oriented to maximize the amount of federal matching funds that can be drawn down for hospitals in communities across the state. The federal Centers for Medicare and Medicaid Services (CMS) has been scrutinizing how county matching funds are acquired to ensure compliance with federal regulations. Federal regulations prohibit use of funds as the non-federal share where the state or county had received donations from private healthcare providers that are related to the amount of Medicaid reimbursement paid to the provider.

A preliminary CMS report has concluded that in certain instances, the non-federal share of SCP payments in FFY09 were based on improper provider donations. A February 2011 CMS draft financial management review of SCP payments found that in nine instances private SCP hospitals had made donations, either via direct payments to the county or, in one case, through in-kind services, that were related to the amounts transferred by the counties to the state to fund SCP payments. The hospitals involved in this report contend that any donations made by them to the counties were unrelated to their Medicaid payments and did not violate federal regulations according to the HSD. Since 2006, the HSD has required counties to certify that the transfers are public money, and in 2010 began requiring hospitals to do the same. Currently, to strengthen this requirement so that arrangements between hospitals and their counties are compliant with federal regulations, the HSD has deferred further SCP payments to private hospitals pending full agreement that the program meets federal requirements. In addition, the HSD is now engaged in negotiations with CMS to resolve the issues raised by the draft report for 2009 in a manner that would eliminate the state's exposure related to SCP payments that have been made until now. The resolution is expected to require a repayment to the federal government of approximately $11.6 million.

In addition, five New Mexico private hospitals have been named in a whistleblower lawsuit alleging that they violated the False Claims Act by making donations to New Mexico counties that were correlated to the amounts transferred by those counties to the state to fund SCP payments to these hospitals. The federal Department of Justice has intervened in the lawsuit with regard to three of the hospitals. The HSD is working with the Department of Justice and CMS to facilitate a resolution to both the lawsuit as well as the federal management review.

In FY11, UNM Hospital assisted with funding the SCP supplemental. Each fall, the HSD calculates the maximum amount of federal funds available for SCP payments after taking into account regular Medicaid payments and what Medicare would have paid for those same services. Based on the allocation prepared by HSD, an amount is determined that must be transferred by the counties to support payment to hospitals of the full available federal funds. In 2010, because of diminishing revenues, the counties were unable to transfer the full amount necessary to access all available federal funds. Working with HSD, UNMH provided the additional amount of non-federal funds required to access the full amount of federal funds. UNMH made payments to the counties who in turn transferred them to the state to facilitate the SCP supplemental totaling $2.3 million to draw down federal match of $11.9 million. As part of this arrangement, the private hospitals agreed to transfer patients back to the sending hospital upon completion of treatment at UNMH.

The continuing need for the SCP program following national healthcare reform is questionable and warrants careful consideration. The impact of the Affordable Care Act on the SCP program is unclear. With the full implementation of national healthcare reform, most individuals will be covered by healthcare insurance and there should be less uncompensated care. Other Medicaid supplemental

payment programs, such as DSH, are scheduled to have funding declines in recognition of the anticipated improved payer mix. New Mexico has one of the highest uninsured rates in the nation, and as more people have a source of payment for care, the continued need for SCP, particularly at current levels, will diminish beginning in 2014. The resources may be redirected toward picking up the eventual state share of newly eligible Medicaid recipients. However, should the state choose to use Medicaid to help finance uncompensated care from residual gaps in coverage, then a smaller SCP program may continue to be needed. For example, some communities may have significant numbers of uninsured immigrants that seek care in local emergency rooms that result in uncompensated care costs.

RECOMMENDATIONS

The HSD, working with counties and hospitals, should develop guidelines for standardized SCP reporting by hospitals to counties to aid with the implementation of Section 27-5-12.2 NMSA 1978 and to aid the HSD's oversight of the program. This report should include, at a minimum, the numbers of indigent patients served (who do not qualify for other payment sources) coupled with their home zip codes, the amounts paid, and unreimbursed costs.

The HSD should post reports on their website that show the full amount of SCP funding, both local and federal, by county, for the SCP program.

The HSD should develop a training module on locally-funded healthcare and make it available for use by the Association of Counties and individual counties.

The SCP funding formula should be revisited and changed to control exponential growth and ensure total Medicaid payments do not exceed the costs of Medicaid and indigent care costs at specific hospitals.

The HSD, working with counties, should ensure local funding for SCP complies with federal regulations and provide a status report to the LFC no later than January 31, 2012 on resolution of outstanding issues stemming from the federal review of SCP payments. The HSD should ensure that any possible repayment of funds does not impact the general fund. The Legislature may wish to consider language in the General Appropriations Act of 2012 to ensure that appropriations from the general fund are not used to finance any SCP refunds.

No later than September 1, 2012, the HSD, working with counties and hospitals, should study and make recommendations to the LFC and governor whether SCP should continue in its current form and financing mechanisms, given federal health reform and state Medicaid redesign.

NEW MEXICO'S HEALTHCARE TAX EXPENDITURES ACCOUNT FOR AN ESTIMATED $290 MILLION IN FOREGONE REVENUE, BUT THEIR TRUE IMPACT IS DIFFICULT TO MEASURE

New Mexico's healthcare tax expenditures lack a clearly defined purpose, adequate reporting requirements from taxpayers, and measurable outcome analysis. There are few specified goals associated with healthcare tax expenditures. Most healthcare tax expenditures only have implied goals and are not specifically targeted. Not having a specifically targeted outcome makes it difficult to ascertain if the expenditure is effective. In addition to clearly defined goals, effective tax expenditures should have clear eligibility criteria and measures that are quantifiable. Of the five tax expenditures selected for review in this evaluation, only one had a specifically stated outcome goal, but none had ways to accurately measure the impact of the provision. However, all five clearly spelled out who is eligible to take the tax credit or deduction.

Table 5. Healthcare Tax Expenditure Scorecard

Tax Expenditure	Foregone Revenue	Clear Health Goal	Clear Eligibility Criteria	Quantifiable Goal Measurement
Rural Practitioner Tax Credit	$6.7 million	*Yes*	*Yes*	*No*
Pre-emption for Those Subject to Premium Tax	$83.6 million	*No*	*Yes*	*No*
NMMIP Assessment Deduction	$49.6 million	*Yes*	*Yes*	*No*
Deduction for Medical Service Providers	$50 million	*No*	*Yes*	*No*
Hospital Credit for GRT	$12.5 million	*No*	*Yes*	*No*

Source: LFC Analysis of FIRs, TRD data, and applicable statutes

The TRD does not systematically collect data on existing tax expenditures, instead relying on forecasting to gauge impact. Currently, neither the Combined Reporting System (CRS) forms for gross receipts taxes, nor the corporate income tax return form, ask for detailed data on which tax credits or deductions are being taken by the taxpayer. Both forms ask for total deductions only. Furthermore, both forms are only two pages in length, with minimal data reporting requirements. This lack of data forces all tax expenditure analysis to be performed on forecasted data, with zero visibility to actual impact of the expenditure. At the LFC hearing in August 2011, TRD officials explained that there is a balance between requiring more information from taxpayers, to measure program effectiveness, and the need to ensure that a tax incentive does not impose a burden on taxpayers, and thus deters participation. For example, small businesses may construe reporting requirements associated with a tax credit as red tape, and thus decide that it is not worth the trouble to participate.

New Mexico is now one of seven states without a formal review of tax expenditures. However, this could change now that the governor has charged the TRD with the responsibility to conduct a comprehensive analysis of all tax expenditures. Additional data will be required to conduct the comprehensive analysis of all tax expenditures, including return on investment analysis and a tax expenditure budget.

Foregone revenue associated with tax expenditures is reported inconsistently. The TRD points out that tax return data is unavailable for many tax provisions and most GRT deductions and exemptions are not separately stated on the return. Data is actually available only for credits affecting small numbers of taxpayers. As a result, information on healthcare tax expenditures is based largely on forecasts. The amount of projected foregone revenue may depend upon who does the forecasting and what assumptions are made. Inconsistencies in projections of foregone revenue, particularly for the NMMIP Assessment Tax Deduction for Insurance Carriers and the Deduction for Medical Service Providers, were observed during this evaluation. Although minimizing the amount of information required from taxpayers reduces administrative and compliance costs, it also has further complicated the development of reliable information for sound public policy decisions.

There is a lack of information regarding the interaction of healthcare tax expenditures with other subsidies. To date, there has not been analysis conducted looking at all public healthcare funding, including tax credits and deductions, hold harmless payments, federal matching programs such as Medicaid and the Sole Community Provider Program, and county-funded programs, such as those for indigent care. Public financing of healthcare in New Mexico is a patchwork quilt of various mechanisms, whose effectiveness cannot be adequately measured due to lack of collected data, resources for analysis, and clearly defined goals for success. Without looking at the system as a whole, there is no way to determine if certain financing instruments are more effective than others in providing healthcare to New Mexicans.

It is very difficult to determine if healthcare outcomes occur because of or in spite of the tax expenditure. In completing this study, LFC was unable to independently determine the effectiveness of the selected tax expenditures due first to a lack of baseline data, and subsequently due to a lack of actual data as opposed to forecasted data. Poor data collection permeates many programs related to healthcare including tax expenditures, the HED's Loan for Service program, and other healthcare funding programs such as the Sole Community Provider Program. Without good baseline and results data, a causal relationship between the programs in question and any changes in the target population cannot be confirmed.

There is little certainty regarding the financial impact of these tax expenditures as they are open-ended. As the healthcare sector continues to grow so will the amount of foregone revenue associated with these tax expenditures. These tax expenditures act as entitlement programs that are removed from the oversight associated with normal expenditures. There is currently little opportunity for public policymakers to exercise control over these growing expenses.

TRD officials testified in August 2011 that one alternative the state should be prepared to consider with tax expenditures versus direct spending is why the tax code would be used rather than direct spending if it is a matter of spending public money to achieve a public purpose.

While the Rural Healthcare Practitioner Tax Credit has a clear goal and is being utilized by rural healthcare providers, its true impact is elusive. The tax credit is intended to increase the recruitment and retention of rural healthcare practitioners in New Mexico. This is an important objective as both the U.S. in general, and New Mexico specifically, are facing a growing shortage of physicians and other healthcare practitioners. According to the Association of Medical Colleges, in 2008, New Mexico ranked 32nd among all states with a rate of 227 active physicians per 100 thousand of population. The national

average is 254.5 physicians per 100 thousand in population. New Mexico ranks 49th nationally in per capita dentists.

This program began in 2007 and was modeled after a similar tax credit program in Oregon. Initially, the number of anticipated professionals claiming the credit was underestimated by 25 percent. When the projections were made, they did not factor in the number of healthcare practitioners who live in urban areas but practice in rural areas. The original concept also included a $3 million cap on the program, which was not included in the final version of HB 638. Hence, the state has foregone more revenue than originally anticipated.

The program provides a personal income tax credit to healthcare practitioners who provide services in rural underserved areas. The credit may be carried forward for three years if the credit exceeds tax liability. The maximum allowable credit for physicians, dentists, osteopathic physicians, clinical psychologists, podiatrists and optometrists is $5 thousand. The maximum allowable credit for dental hygienists, physician assistants, certified nurse-midwives, certified registered nurse anesthetists, certified nurse practitioners or clinical nurse specialists is $3 thousand. The DOH determines whether the practitioner's application qualifies for the credit and issues a certificate to the TRD. The credit is effective for tax years beginning with 2007.

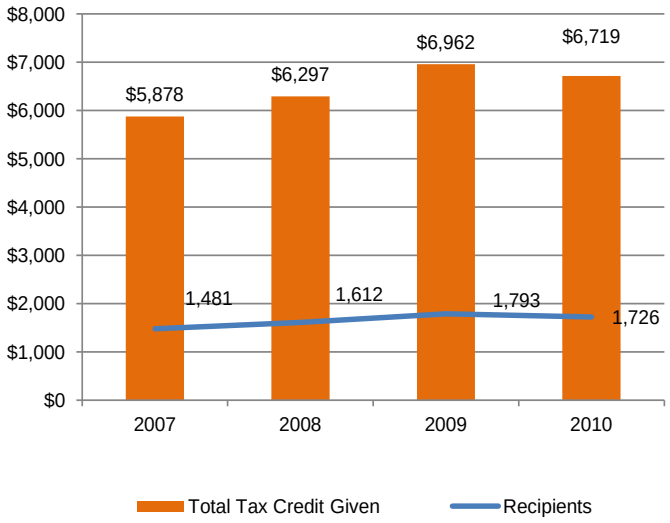
Data collected by the New Mexico Health Policy Commission reveals a slowly growing physician population that is getting older and that is still insufficient to meet projected healthcare needs. The number of licensed physicians in New Mexico grew from 4,478 in 2007 to 4,689 in 2009 – a 4.7 percent increase. New Mexico has the distinction of ranking 4th nationally with 27.2 percent of active physicians age 60 or older, when the national average is 24.7 percent. In 2009, 47.9 percent of New Mexico licensed physicians were age 55 and over. The Health Policy Commission estimates that New Mexico is short 400 to 600 full time primary care physicians, and that the current nursing shortage of 1 thousand nurses will triple by 2015.

There are certain aspects to consider when looking at healthcare practitioner recruitment and retention. According to New Mexico Health Resources, on average, a current rural primary care physician earns $160 thousand to $180 thousand annually. In 2011, a new medical graduate is looking at an average starting salary of $202 thousand per year. Fifty percent of physicians remain in a particular rural location for three years, twelve percent leave within one year. Those who stay tend to do so because of loan repayment programs, although HED does not track length of stay for those in the State Loan Repayment Program.

The State Loan Repayment Program (SLP) is administered by the NMHED. Awards range from $25 thousand to a maximum of $35 thousand, depending on whether the funding source is federal or exclusively state general fund. Over 200 individuals apply each year for the SLP. However, the number of new awards under the state program has declined in recent years because of increased debt load of eligible participants. The SLP funded about 112 applicants in the last five years with approximately 12 new awards in 2011.

The National Health Service Corps (NHSC) also has a completely federally-funded loan repayment program that awards up to $170 thousand over five-year periods. Fewer awards are expected with continued federal deficit shortfalls.

Graph 7. Rural Provider Tax Credit Program Growth
(Dollars in thousands)



Maximum Potential Foregone Revenue Resources

Source: NM Health

The Rural Healthcare Practitioner Tax Credit has a clear goal but evidence that it is achieving this goal is anecdotal. This tax expenditure's goal is the recruitment and retention of healthcare professionals in rural, underserved areas of the state. Although well liked by those taking the credit or using it to recruit or retain professionals, it remains difficult to say if it is directly accomplishing its goal other than anecdotally. For example, it's unclear that a $5 thousand tax credit would be the deciding factor in where an individual making $180 thousand per year chooses to work. The number of rural healthcare providers is growing, but New Mexico still has a troubling shortage of healthcare practitioners, a problem that will impact the implementation of national healthcare reform.

In practice, the tax credit program is better understood as a retention tool, rather than a recruitment tool. There are a number of retention incentives for healthcare providers in the form of loan repayment programs – either through the federal government or through the state. According to New Mexico Healthcare Resources, there are no incentive programs other than the tax credit program for mid-career health professionals who have little or no debt.

The tax credit program has grown much larger than originally expected and the state has seen a much larger loss of tax revenue than anticipated. As originally conceived, the program would have had a $3 million cap. This did not survive in the final legislation that passed as HB 638. The maximum potential foregone revenue associated with this tax expenditure has averaged $6.5 million per year. Neither the DOH nor the TRD collect data on the actual credit amounts taken each year. Only the maximum potential tax credit amounts are captured. Originally, fewer healthcare professionals were expected to take the credit since, at the time, it was not known that 25 percent of practitioners live in urban areas and work, at least part time, in rural areas. It would be in New Mexico's interest to continue to explore if there are more effective and economical recruitment and retention tools.

An accurate count of rural practitioners is not currently available. At this time, there is no mechanism for accurately collecting information on the number of physicians practicing in rural areas, other than from the rural healthcare practitioner tax credit program. So it is difficult to compare the numbers of rural

practitioners before and after the implementation of the credit in 2007. Most information regarding healthcare practitioner distribution is gathered from licensure data. As practice addresses are not verified, it is not possible to determine if a person is licensed but not practicing, o is practicing in multiple locations, in different counties, or in another state. It is also not possible to determine the number of hours an individual is working based on licensure data.

Other methods to recruit and retain healthcare professionals may be more effective. For example, the Colorado Rural Outreach Program (CROP) provides grants to recruit new healthcare professionals or retain the ones already on staff by repaying portions of the healthcare professional's educational loans, or by giving a retention bonus if all educational loans are paid off. These grants require local matching funds, equal to the proposed award amount, up to a maximum of $10 thousand, making the total possible award $20 thousand. Rural healthcare professionals who are eligible include physicians, nurse practitioners, physician assistants, nurses, providers of mental health services, providers of dental health services, allied health professionals, physical therapists and pharmacists. The same healthcare professional can be awarded up to three times, but preference is given to new applicants. CROP grants may also be used for recruitment.

Contracts with managed care organizations spell out a responsibility to comply with state access to Access to Service requirements. The MCO must demonstrate that its network is sufficient to meet the healthcare needs of enrolled members. These administrative rules spell out that there should be one primary care provider per 1.5 thousand members and that 90 percent of rural residents shall travel no farther than 45 miles, 60 miles for residents of frontier areas, to access a provider.

The DOH healthcare work group was established under the Health Care Work Force Data Collection, Analysis and Policy Act passed in 2011. This legislation directs the New Mexico Department of Health to collect and analyze data on the state's healthcare work force utilizing enhanced data collection from all healthcare licensing/regulatory boards. The bill also requires that a work group be established to explore the use of provider incentives and to develop a plan for provider recruitment and retention. In January 2011, the HPC released a study that recommended 12 areas to explore to decrease healthcare workforce shortages in the state (see **Appendix H**). These strategies include a mix of additional stipends and rural community contracts, enhanced scholarships and loan repayment programs, expanded federally subsidized graduate medical education residencies, and expansion of mid-level provider programs in medical and oral health areas.

The Hospital GRT Tax Credit results in for-profit hospitals paying zero state GRT by FY12 and going forward – resulting in an estimated $12.5 million in foregone revenue growing to $14 million by FY15. A report by the Hilltop Institute of the University of Maryland, commissioned by the HSD, looked at aggregate revenues and expenses for New Mexico's hospitals for the years 2006 to 2008. The overall net profit margin of New Mexico's hospitals of 9.8 percent exceeded the net profit margins in the hospitals in four benchmark states (Arizona, Colorado, Oklahoma and Texas), as well as the national average of 2.6 percent. In 2008, New Mexico hospitals' total net revenue was $3.4 billion and net profits amounted to over $337 million.

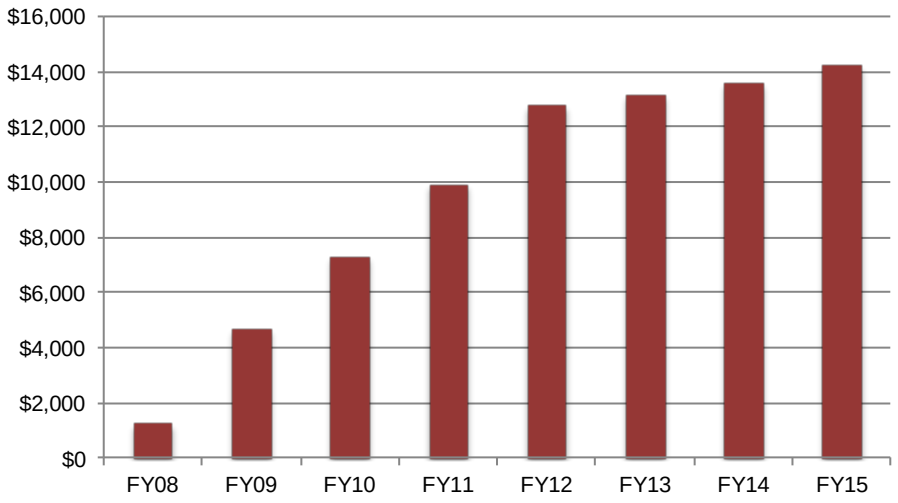
This tax credit was apparently instituted to level the playing field for for-profit hospitals. About half of New Mexico's hospitals are for-profit. For-profit hospitals compete with nonprofit hospitals in New Mexico and hospitals in neighboring states that do not pay gross receipts tax. The New Mexico Hospital

Association reported that HB 638 would remove a competitive disadvantage against New Mexico's for-profit hospitals.

New Mexico law allows for-profit hospitals to qualify for a 50 percent gross receipts tax deduction. In 2007, HB 638 effectively reduced the gross receipts tax paid by for-profit hospitals from 50 percent of the normal state rate to zero once it is fully phased-in in FY12. Specifically, HB 638 created a gross receipts tax credit that equals approximately 20 percent of the state gross receipts tax rate in FY08, 40 percent in FY09, 60 percent in FY10, 80 percent in FY11, and the entire state gross receipts tax rate in FY12 and beyond.

All of the state's for-profit hospitals are currently located within municipal areas, where the state tax rate is 3.775 percent. Therefore, the credit eliminates the state gross receipts tax paid by for-profit hospitals once it is fully phased in. The bill does not apply to local option gross receipts taxes, so for-profit hospitals will still pay a little over 1 percent local gross receipts tax. No evidence is available to suggest that reducing the GRT liability of New Mexico for-profit hospitals has resulted in reduced costs to patients or insurance plans.

Graph 8. Hospital GRT Forecasted Credit Taken
(In thousands)



Source: TRD

The pre-emption of all other taxes for insurance companies subject to the premium tax results in a large amount of foregone revenue with unclear policy goals. Under the premium tax statute, health and life insurers pay 4 percent tax on gross premiums received from their insured in lieu of paying other taxes. Premium tax and the associated pre-emption are administered by the Insurance Division of the PRC (DOI). While there is not a clearly defined purpose to this tax expenditure, it is implied that the pre-emption makes New Mexico a more attractive business environment in which insurers can operate.

The pre-emption of all other taxes for insurers created foregone GRT revenue for tax year 2010 of $83.6 million. While the premium tax is high in comparison to other states, insurers still receive a substantial benefit from paying 4 percent on premiums instead of the state GRT rate of 5.125 percent. For

example, for FY10, foregone state GRT revenue for health and life insurers under the pre-emption based on gross premiums totaled $83.6 million.

New Mexico's premium tax is more competitive when compared to other state taxation policies for insurers. When comparing insurer tax burden in New Mexico to other states, looking at premium tax rates alone could paint a false picture of how competitive New Mexico's premium tax rate is. In New York, for example, insurers are subject to various taxes including corporate income tax and premium tax. While their premium tax rate is between 0.7 percent and 1.75 percent, the overall tax rate for insurers can be as high as 7.96 percent. In Maine, there is no premium tax, but insurers are subject to the corporate income tax rate, which is as high as 8.93 percent. Having a pre-emption to other taxes for insurers in New Mexico offsets the impact of having a higher premium tax. Additional state tax rates related to insurers are listed in **Appendix D**.

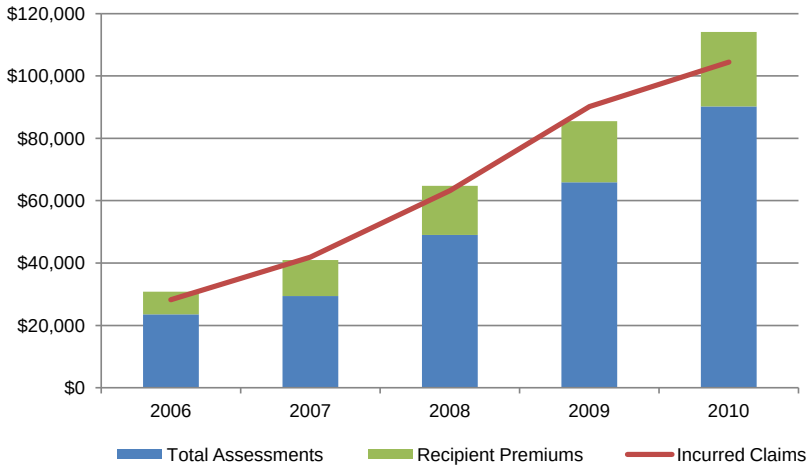
There are exclusions to the premium tax which result in large amounts of foregone revenue to the state. Under the premium tax statute, health insurers pay 4 percent tax on gross premiums received from their insured. However, administrative services only (ASO) contracts are not subject to premium tax, as they are considered service contracts under the Service Contract Regulation Act. An example of a large ASO contract is the GSD-administered plan for state employees. Under this contract, the state assumes the entire risk for healthcare claims and maintains reserves from the general fund and from employee premiums to pay claims. Under the ASO agreement, insurers provide administrative services which include processing claims, advice on plan design, and printing of benefits booklets. In FY11, the state paid $12.4 million for these services, which was not subject to premium tax, resulting in foregone tax revenue of $496 thousand.

MCOs pay premium tax for Medicaid programs, making the state a significant contributor to premium tax revenue going into the general fund. In FY10, Medicaid programs spent approximately $2.3 billion tasking MCOs to run the Salud!, CoLTS, and the Behavioral Health managed care programs. This resulted in an estimated $152 million coming back to the state general fund in premium tax revenue.

The NMMIP Assessment Tax Deduction for insurance carriers accounted for $49.6 million in foregone revenue for tax year 2010, but will no longer be needed after national healthcare reform is implemented in 2014. All health and life insurers operating within the state of New Mexico are subject to paying an assessment fee to subsidize premiums paid into the New Mexico Medical Insurance Pool (NMMIP). Any surplus assessment funds after all claims are paid are then reimbursed to insurers. The assessment is the only specifically earmarked fee, bypassing the general fund and going directly to the New Mexico Medical Insurance Pool. Therefore, health and life insurers pay the base premium tax of 3 percent, a surtax of 1 percent specific to health and life premiums only, and the NMMIP assessment. Associated with the NMMIP assessment is a premium tax deduction administered by the Insurance Division of the PRC. Insurers subject to the NMMIP assessment are able to deduct 50 percent, and in some cases 75 percent, of total assessments paid off of their premium tax obligation.

The NMMIP assessment accounted for $90 million in state revenue earmarked for a specific purpose in tax year 2010. In 2010, assessments to insurers accounted for $90.2 million, an increase of 37 percent over 2009. These funds bypass the general appropriation process and are not subject to legislative scrutiny.

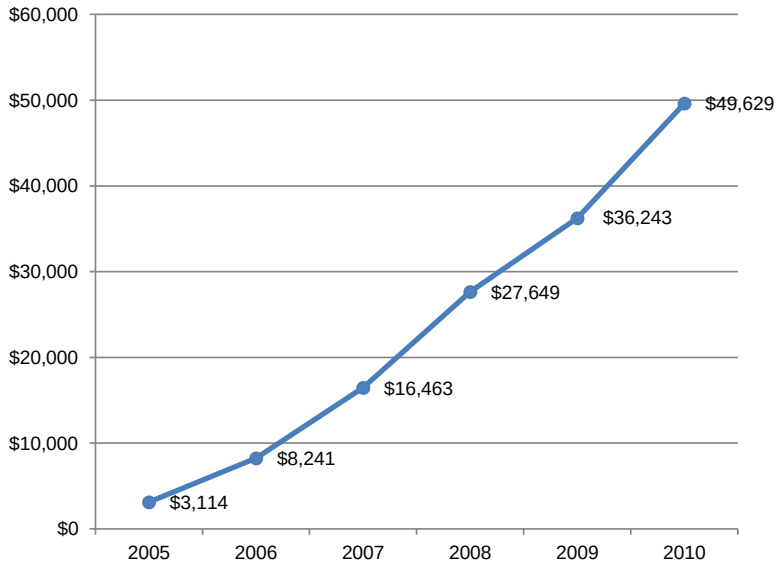
Graph 9. NMMIP Claims and Assessments
(In thousands)



Source: Leif Associates on behalf of NMMIP/NMMIP

New Mexico Insurers' effective tax rate should be an estimated 3.5 percent once the NMMIP assessment deduction is applied, but data issues at the DOI made this unverifiable. New Mexico has the second highest premium tax rate on health insurers at 4 percent, ranking behind Tennessee, whose rate is 5.5 percent. However, insurers subject to the NMMIP assessment receive a reduction to their effective premium tax rate through a 50 percent tax deduction. For tax year 2010, health insurers operating in New Mexico collected $2.7 billion in premiums, which would have generated $107 million at the 4 percent premium tax rate. This left a total tax liability for insurers of $52.7 million, of which DOI reported collecting $51 million. In obtaining this data, there were concerns over data integrity within the DOI database tracking premium taxes and premiums written in New Mexico. In 2005, LFC completed a report emphasizing data integrity and reporting concerns within DOI. This continues to be a significant concern in the accurate measurement of tax expenditures for taxes that fall under DOI management.

Graph 10. NMMIP Assessment Credit Growth Rate
(In thousands)



Source: Leif Associates on behalf of NMMIP

If NMMIP is no longer required as a result of healthcare reform, both the NMMIP assessment and the corresponding deduction should be addressed statutorily. If New Mexico dissolves NMMIP and moves the members of the pool into Medicaid or a state healthcare exchange, both the assessment and the tax deduction need to be reviewed. The premium tax revenue gained by eliminating the NMMIP tax deduction could potentially bring $49 million back into the general fund based on 2010 data.

The GRT tax deduction for medical service providers, coupled with a corresponding hold harmless for local governments, represents a double impact where the state is losing revenue through a tax expenditure and a direct general fund expenditure to localities.

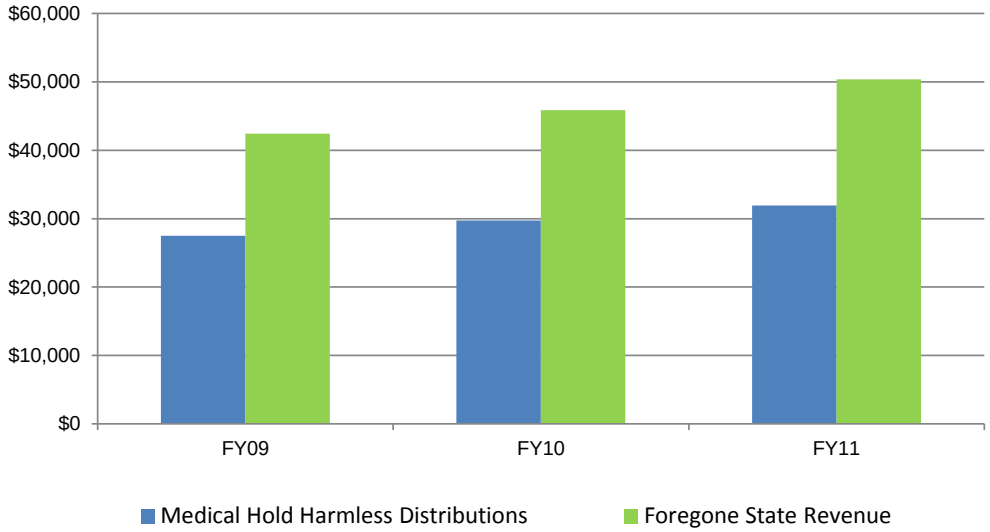
In 2004, HB 625 repealed the gross receipts tax for food and certain medical services, while also creating new distributions to cities and counties. The hold harmless distribution was created to offset local option GRT revenue losses due to this repeal. In reference to medical services, HB 625 states:

> Receipts from payments by a managed healthcare provider or healthcare insurer for commercial contract services or Medicare part C services provided by a health care practitioner… may be deducted from gross receipts.

Tax code states that this deduction, while named as being for managed care, refers to providers who receive payments from any organized plan network, including HMO and PPO plans. Therefore, virtually all medical services are exempt from GRT.

Total general fund impact for foregone GRT revenue plus hold harmless payouts to municipalities under the medical GRT repeal totaled $82 million for FY11. While counties and municipalities are receiving general fund support from the state to offset lost GRT for medical services, the state is losing the opportunity to appropriate these funds to federally matched programs which could potentially alleviate county burdens. For example, with the plans to redesign Medicaid, the Legislature could designate these hold harmless funds to offset any associated costs for program changes.

Graph 11. Estimated State Foregone Revenue from Medical Care Deductions and Hold Harmless Payouts
(In thousands)



The purpose of the medical service provider deduction is not clearly defined. Similar to other tax expenditures reviewed in this evaluation, the medical service provider deduction does not have a specific and measureable purpose. However, in the fiscal impact report completed by LFC, it was speculated first that eliminating the tax would increase provider take home pay, facilitating recruitment and retention of providers in New Mexico. Second, providers practicing under managed care plans would not be able to pass the tax burden on to consumers. Third, the deduction would also correct the fact that New Mexico was one of only two states in 2004 that taxed health providers' receipts under a sales or gross receipts tax, which sent a bad signal regarding the state's medical business climate.

RECOMMENDATIONS

The TRD should work to collect data on the financial impact of healthcare tax expenditures through a more detailed and transparent CRS form, rather than relying solely on forecasting. Options include allowing additional form sections for taxpayers to detail credits and deductions being taken, as this data should be readily available, or asking for the five largest tax expenditures to be detailed on the CRS form. This will provide fundamental data for the analysis of tax expenditures and ultimately for the development of a tax expenditure budget.

Support recommendations in the LFC staff brief on the inventory of New Mexico's tax expenditures presented to the LFC on August 19, 2011:

- TRD leads development of tax expenditure report
- New healthcare tax expenditures subject to thorough review
- Consider caps and/or sunset provisions

The DOH SB14 work group should consider the following:

- Progressively narrow the tax credit to practices in the neediest areas of the state;
- Survey providers taking the tax expenditure to validate that the Rural Healthcare Practitioner Credit indeed attracts and retains healthcare professionals in rural areas;
- Explore direct expenditure alternatives (grants, bonuses, etc.) to the Rural Healthcare Practitioner Credit;
- Look at the HPC 2011 report on ways to recruit and retain providers – cite the report and suggest following up on some of its recommendations;
- Review devices, such as incentive bonuses, to keep providers in rural areas beyond the average 3 years;
- Recommend the funding of additional rural residency programs; and
- Continue to evaluate the effectiveness of the Rural Healthcare Practitioner Credit by monitoring rural placement trends and rates of retention.

The DOH work group should make legislative recommendations no later than September 1, 2012.

At the time that the DOH workgroup makes its recommendations, the Legislature should consider capping the Healthcare Provider Tax Credit at $15 million per year.

The Legislature should work to phase out the hold harmless provision of the medical service providers deduction for GRT, and redistribute these funds to federally-matchable programs as the need for local financing of healthcare diminishes.

New Mexico Human Services Department

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Susana Martinez, Governor
Sidonie Squier, Secretary

December 2, 2011

Mr. David Abbey, Director
Legislative Finance Committee
325 Don Gaspar, Suite 101
Santa Fe, New Mexico 87501

RE: HSD Response to LFC "The Impact of Financing Healthcare through Tax Code Policy and Local Counties" Evaluation Report

Dear Mr. Abbey:

Please accept this document as the Human Services Department's (HSD) response to the Legislative Finance Committee's (LFC) draft "The Impact of Financing Healthcare through Tax Code Policy and Local Counties" evaluation report. The response is intended to clearly describe HSD's position on the LFC's report.

By way of general comment, it is important to understand the role and purpose of the Sole Community Provider program for New Mexico's rural hospitals. The program was established in statute to help counties and hospitals meet local health care needs. The program was not created for HSD but rather designed to support hospitals that are generally the sole source of care for individuals in a community. So while the program was established within the Indigent Health Care Act, its purpose is broader than indigent care. Specifically, the program:

- Acknowledges that hospitals and hospital emergency rooms were often the care provider of last resort and that costs associated with that situation would require additional reimbursement;
- Takes into consideration under-compensated care for individuals on public assistance programs; and
- Recognizes that due to the rural nature of SCP hospitals, incentives are often required to attract qualified healthcare professionals.

In some cases, this evaluation did not recognize the broader purpose of the program or identify the correct decision-making body. Instead, the evaluation focused almost exclusively on indigent care and HSD's role. This led to incorrect findings and unnecessary or misdirected recommendations.

Nevertheless, the evaluation report raises some important issues for consideration by the Legislature, counties, hospitals, and the Human Services Department. Given the increased scrutiny under which the Sole Community Provider program has been operating, Governor Martinez's administration, via HSD, has taken a more direct role in ensuring that this program and its beneficiaries comply with federal law.

The Department will continue to work with counties, hospitals and the Legislature to improve the program's design and function, including more accountability reporting for counties, hospitals and the public.

Our responses to the specific recommendations are included below.

RECOMMENDATIONS

The HSD should continue to make available on its website a County-Supported Medicaid Fund report showing Medicaid enrollment in each county. Information should also be included regarding Medicaid expenditures in each county.

HSD Response: HSD will continue to report Medicaid enrollment by county on the Department's website, and while not statutorily required, will post a report containing expenditures by county on the Department's website on a quarterly basis.

The Department notes that the findings leading to this recommendation overstate the purpose of this statutorily created tax and fund. This tax and fund were established to raise revenue for general Medicaid purposes, offsetting an otherwise needed appropriation from the state general fund. While, as stated above, the Department will continue to provide information to the counties, the findings in this report suggested an expanded purpose of the statute.

The HSD should develop guidelines for standardized SCP reporting by hospitals to counties to aid with the implementation of Section 27-5-12.2 NMSA 1978 and to aid HSD's oversight of the program. This report should include, at a minimum, the numbers of indigent patients served (who do not qualify for other payment sources) coupled with their home zip codes and the amounts paid and unreimbursed costs.

HSD Response: HSD is compliant with the current statute, which directs the counties and hospitals to jointly agree on the report format. The Department is unclear why this recommendation was not directed to county governments and hospitals which are required by statute to develop these reports.

Section 27-5-12.2 NMSA 1978 details duties of the county with regard to Sole Community Provider Hospital Payments. Section C of the statute states, "confirm the amount of the sole community provider hospital payments authorized for each hospital for the past fiscal year by September 30 of the current fiscal year based on a report prepared by the hospital using a format jointly prescribed by the counties and hospitals that provides aggregate data, including the number of indigent patients served and the total cost of the uncompensated care provided by the hospital."

The HSD should post reports on their website that show the full amount of SCP funding, both local and federal, by county, for the SCP program.

HSD Response: HSD has made this information available upon request and, although not statutorily required, will post the information on the Department's website.

The HSD should develop a training module on locally-funded health care and make it available for use by the Association of Counties and individual counties. This could be posted on their website.

HSD Response: HSD has previously developed and currently uses a PowerPoint presentation which will be made available on the Department's website.

The SCP funding formula should be revisited and changed to control exponential growth, and ensure total Medicaid payments do not exceed the costs of Medicaid and indigent care at specific hospitals.

HSD Response: HSD does not disagree that the funding formula should be revisited. However, HSD is concerned about the findings that led to the second part of this recommendation. The data is outdated and inadequate to draw the stated recommendations. Some examples of this concern are:

- The data is from 2007 and does not provide an accurate view of current Medicaid payments. Medicaid reimbursements to hospitals were reduced in 2009, 2010 and 2011. These reductions significantly impacted hospital payments and are not reflected or discussed in this report.
- The 2007 Disproportionate Share Hospital (DSH) Audit Report that the data was pulled from is an audit required by CMS to determine that qualifying hospitals receiving DSH are not exceeding their hospital-specific DSH limit.
- The Department reviews hospital cost reports and other data to determine Medicaid reimbursement rates and policies, which is not recognized in the evaluation report.

The HSD, working with counties, should ensure local funding for SCP complies with federal regulations and provide a status report to the LFC no later than January 31, 2011 on resolution of outstanding issues stemming from the federal review of SCP payments. The HSD should ensure that any possible repayment of funds does not impact the general fund. The Legislature may wish to consider language in the General Appropriations Act of 2012 to ensure that appropriations from the general fund are not used to finance any SCP refunds.

HSD Response: The Department engaged outside counsel to support the Department's efforts to address concerns raised by the Centers for Medicare and Medicaid Services (CMS). The Department is negotiating a resolution with CMS that will put the program on solid footing and allow continued funding for New Mexico's rural and teaching hospitals. The Department will report to the LFC at the time of resolution.

No later than September 1, 2012, the HSD, working with counties and hospitals, should study and make recommendations to the LFC and Governor whether SCP should continue in its current form and financing mechanisms given federal health reform and state Medicaid redesign.

HSD response: HSD has been studying all Medicaid programs to determine the impact of Medicaid Modernization and the federal health care reform law. This report suggests that the Sole Community Provider program will not be necessary after the implementation of the Patient Protection and Affordable Care Act (PPACA). Given the uncertainties about the implementation and effectiveness of PPACA, the Department would suggest a more cautious outlook for the necessity of this and other programs that support rural hospitals or indigent care.

HSD respectfully submits the response to describe the Department's position of this report. HSD is committed to continued collaboration with the LFC and looks forward to future opportunities in that regard.

Sincerely,

/s/

Sidonie Squier
Cabinet Secretary

The TRD did not provide a response to this evaluation.

FILE

October 19, 2011

Mr. David Abbey, Director
Legislative Finance Committee
325 Don Gaspar, Suite 101
Santa Fe, NM 87501

Dear Mr. Abbey:

Thank you for allowing us this opportunity to respond to the LFC report on the New Mexico Healthcare Tax Policy evaluation, specifically the Rural Healthcare Practitioner Tax Credit. We would like to express our appreciation to Mr. Jack Evans and the Legislative Finance Committee (LFC) for their professionalism and the knowledge base they demonstrated in conducting the evaluation. They offered valuable recommendations that will be considered by the Department.

The draft report recognizes, as does the Department of Health (DOH), that there are many challenges involved in maximizing the effectiveness of this tax credit program. The Department agrees with many of the findings and recommendations.

Upon review, DOH did not identify any inaccuracies or other issues that would compromise the accuracy of the report. DOH would also like the opportunity to provide additional information related to the recommendations noted in the report as related to the Rural Healthcare Practitioner Tax Credit. Those comments are noted below.

"Support the work of the DOH in implementing SB14. Given the lack of good information on rural healthcare providers, the DOH workgroup should consider the following:"

- ***Consider progressively narrowing the tax credit to practices in the neediest areas of the state.***

  Limit eligibility to those practitioners that are practicing in Health Provider Shortage Designations (HPSAs), Medically Underserved Areas (MUAs), and Medically Underserved Populations (MUPs). There would be a need to establish a similar scoring method such as the one National Health Service Corps (NHSC) uses to place NHSC loan re-payers. Those employed in a Community Health Clinics are automatically eligible for loan repayment

NEW MEXICO CENTENNIAL

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- ***Consider surveying providers taking tax expenditure to validate that the Rural Healthcare Practitioner Credit indeed attracts and retains healthcare professionals in rural areas.***

  This is a consideration for the Office of Primary Care and Rural Health, and has been discussed with program staff. The survey would be completed during the application process or a separate survey could be distributed to providers.

- ***Explore direct expenditure alternatives (grants, bonuses, etc.) to the Rural Healthcare Practitioner Credit.***

  Review of the CROP program, this program is housed within the Colorado Rural Health Center, which is an independent, nonprofit membership based organization the serves as the State Office of Rural Health, various foundations and private donations support the CROP grants. The Rural Health Provider Tax Credit program is managed by the NMDOH, and is not supported by any grants.

- ***Look at the HPC 2011 report on ways to recruit and retain providers – cite the report and suggest following up on some of its recommendations.***

  This program is administered by the NM Department of Higher Education. The DOH will begin to have a dialog with the NM Department of Higher Education to discuss recommendations published in the above mentioned report.

- ***Consider devices, such as incentive bonuses, to keep providers in rural areas beyond the average 3 years.***

  The New Mexico Health Service Corps (NMHSC) Community/Practice Site Contract is to support the retention of health professionals at existing eligible practice sites that are located in specific, rural and other medically underserved areas of the state. The DOH healthcare workgroup which was established during the 2011 Legislative Session is charged with collecting and analyzing this type of data. Upon completion of the analysis, the workgroup will develop recommendations and a plan to address the high turnover of providers in rural areas throughout New Mexico.

- ***Consider recommending the funding of additional rural residency programs.***

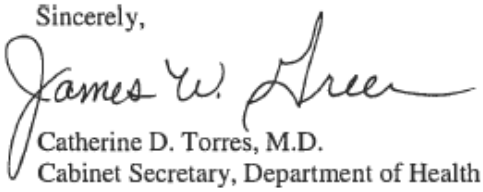
  Utilize all available resources for rural residency programs that strengthen rural health career pathways, utilizing a variety of education and rural training opportunities, and improving career opportunities and support for current rural providers to reduce professional isolation.

- ***Continue to evaluate the effectiveness of the Rural Healthcare Practitioner Credit by monitoring rural placement trends and rates of retention.***

  This is a consideration for the Office of Primary Care and Rural Health by expanding the scope of work to the recruitment and retention clearinghouse contract. Nationally there are ARRA funds to monitor effectiveness of rural placement trends and rates of retention. DOH has been awarded additional ARRA funds for this purpose in previous years.

Again, we appreciate the opportunity you have given us to respond to the report. If you require any additional information related to this response, please contact me at (505) 827-2951.

Sincerely,



Catherine D. Torres, M.D.
Cabinet Secretary, Department of Health

NEW MEXICO PUBLIC REGULATION COMMISSION

Office of the Superintendent
P.O. Box 1269
1120 Paseo De Peralta
Santa Fe, NM 87504-1269
(505)827-4297

Superintendent of Insurance
John G. Franchini

October 19, 2011

Maria D. Griego
Legislative Finance Committee
State Capitol North
325 Don Gaspar, Suite 101
Santa Fe, NM 87501

Re: Healthcare Tax Policy Evaluation

Dear Ms. Griego:

We wish to formally submit the following comments to Findings and Recommendations contained in the Legislative Finance Committee's October 12 draft Healthcare Tax Policy Evaluation.

"The pre-emption of all other taxes for insurance companies subject to the Premiums Tax results in a large amount of foregone revenue with unclear policy goals."

This Finding appears to contain a recommendation that the Legislature discontinue this pre-emption. We believe that such a recommendation would be unwise since most states, including New Mexico, charge insurers premium tax in lieu of other forms of taxation. New Mexico already levies upon health insurers one of the highest tax rates in the nation. Raising this tax burden even higher would increase the health insurance premiums that New Mexico consumers and businesses pay and would make the business environment in New Mexico even less attractive for health insurers.

"The NMMIP Assessment Tax Deduction for insurance carriers accounted for $49.6 million in foregone revenue for tax year 2010, but will no longer be needed after national healthcare reform is implemented in 2014."

Contained within this Finding is a concern regarding the "data integrity within the DOI database tracking premium taxes and premiums written in New Mexico" and the "accurate measurement of tax expenditures for taxes that fall under DOI management." Please be advised that we propose to resolve this matter by conducting a joint audit with NMMIP and NMHIA of the calculation and collection of health insurance premium taxes and assessments and to report our findings from this audit to the LFC in early 2012.

Please let us know if you have any questions or considerations regarding these comments.

Sincerely,

John G. Franchini
Superintendent of Insurance

NEW MEXICO ASSOCIATION OF COUNTIES

December 5, 2011

David Abbey
Director, Legislative Finance Committee
325 Don Gaspar
Suite 101
Santa Fe, NM 87505

Re: LFC Study: Impact of Financing Healthcare through Tax Code Policy and Local Counties

Dear Mr. Abbey:

On behalf of the New Mexico Association of Counties (NMAC) staff and the NMAC Health Care Affiliate, we would like thank your staff for taking the time to meet with several of our members on the LFC study, "The Impact of Financing Healthcare through Tax Code Policy and Local Counties." We appreciate the work of Charles Sallee, Jack Evans, and Maria Griego. They conducted a thoughtful and useful study of the various programs financed by counties. The staff took the time to meet with county health care practitioners and policy personnel to gain the county perspective of the healthcare programs offered and financed at the local level. They also took the time to allow the individuals they interviewed to review the draft report and to make changes to the report if there were substantial reservations about the report. Finally, the LFC staff worked to provide some sensible recommendations.

The New Mexico Association of Counties will work with the Legislature, the NM Hospital Association and the Human Service Department to continue to support health care to the neediest of New Mexicans. The report makes several recommendations which NMAC supports. We have supported increased transparency in health care funding and are working with the NMHA and HSD to find a useful reporting mechanism. We are working together and have stated the desire to continue to work together on future funding for the Sole Community Provider Program.

Again, we thank the LFC staff for taking the time to discuss the program and to take input from the county health coordinators. We look forward to working with the staff in the future.

Paul Gutierrez

Executive Director

Cc: Legislative Finance Committee Members

613 Old Santa Fe Trail
Santa Fe, NM 87505
www.nmcounties.org
877.983.2101 or 505.983.2101 Phone
505.983.4396 Fax

APPENDIX A: Summary of Locally-Financed Programs: Sources and Uses of Funds

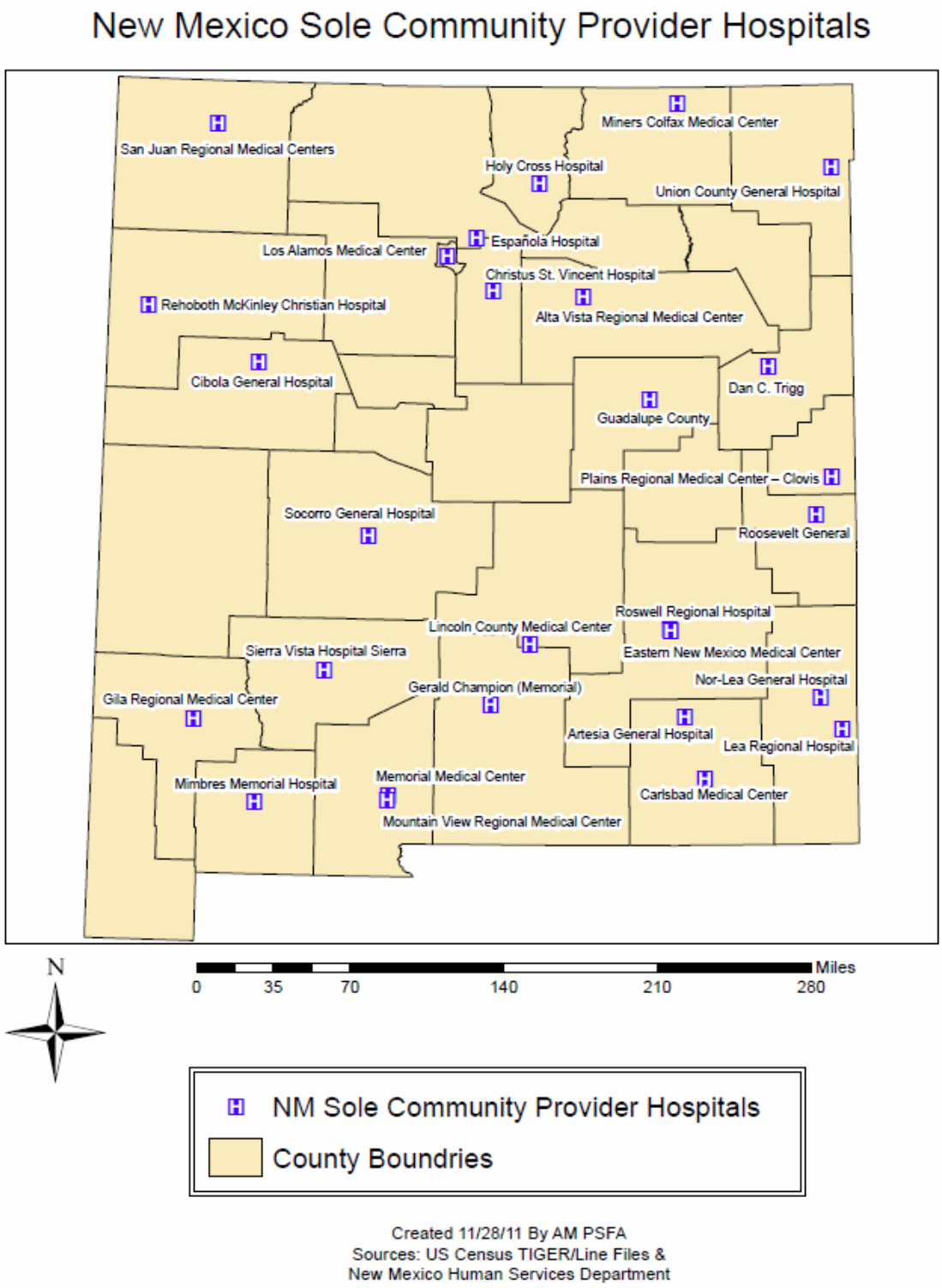
LOCALLY-FINANCED HEALTHCARE

	Indigent Care Funds	Sole Community Provider Program	UPL/Supplemental SCP Funding	County-Supported Medicaid Fund
Statute	7-20E-9 27-5-5.1	27-5-6.1 (1993)	27-5-6.1; 2 C.F.R. 412.92	7-20E-18; 27-5-7.1; 27-10-3; 27-10-4
Amount Raised Statewide	FY09: $23.6 million	FY11: $41 million (county funds)	FY11: $8.7 million (county funds)	FY11: $23.5 million
How Financed	2nd 1/8th GRT Increment 50% of 3rd 1/8th GRT Increment	Primarily through the use of Indigent Care Funds. Some counties us Hospital Mill Levies or Other County Revenues	Hospital Mill Levies or Other County Revenues	Other County Funds or 1/16th GRT Increment. ("other" = an amount from any existing authorized county revenue source)
What is funded	County determines health needs to be funded. May also transfer funds to SCP and CSMF funds	Uncompensated care in SCP hospitals; maintain access to SCP for Medicaid clients	The difference between what Medicaid paid for hospital care and what Medicare would have paid	The Medicaid program, primary care clinics (9%) And administration (3%)
Who controls	County determines healthcare services it intends to support	County and hospital negotiate annual budget- January to February each year	County and hospital negotiate – August to September each year	State statute
How Payments are Determined	County determines annual budget; may be claims-based	Maximum budget is based on a formula: last year's SCP budget plus last year's supplemental payment plus market basket index	HSD (and auditors) determine upper payment limit; difference between what Medicaid paid and what Medicare would have paid	Set in statute
When Payments are Made	County determines payment schedule	Payments are made in quarterly increments	One-time supplemental payment	One time per year
Is it Matchable?	No	Yes	Yes	Yes
Is it Mandatory?	Yes, once the county has imposed the GRT increment	No	No	Yes

APPENDIX B: New Mexico Sole Community Provider Hospitals

Hospital	County (City)
Privately Owned and Operated:	
Carlsbad Medical Center	Eddy (Carlsbad)
Eastern New Mexico Medical Center	Chaves (Roswell)
Española Hospital	Rio Arriba (Española)
Gerald Champion (Memorial)	Otero (Alamogordo)
Lea Regional Hospital	Lea (Hobbs)
Los Alamos Medical Center	Los Alamos (Los Alamos)
Mimbres Memorial Hospital	Luna (Deming)
Mountain View Regional Medical Center	Doña Ana (Las Cruces)
Alta Vista Regional Medical Center	San Miguel (Las Vegas)
Plains Regional Medical Center – Clovis	Curry (Clovis)
Socorro General Hospital	Socorro (Socorro)
Christus St. Vincent Hospital	Santa Fe (Santa Fe)
Rehoboth McKinley Christian Hospital	McKinley (Gallup)
Roswell Regional Hospital	Chavez (Roswell)
Government Owned/Operated:	
Artesia General Hospital	Eddy (Artesia)
Cibola General Hospital	Cibola (Grants)
Dan C. Trigg	Quay (Tucumcari)
Guadalupe County	Guadalupe (Santa Rosa)
Holy Cross Hospital	Taos (Taos)
Lincoln County Medical Center	Lincoln (Ruidoso)
Memorial Medical Center	Doña Ana (Las Cruces)
Nor-Lea General Hospital	Lea (Lovington)
Gila Regional Medical Center	Grant (Silver City)
San Juan Regional Medical Centers	San Juan (Farmington)
Sierra Vista Hospital Sierra	Sierra (Truth or Consequences)
Union County General Hospital	Union (Clayton)
Roosevelt General	Roosevelt (Portales)
Miners Colfax Medical Center	Colfax (Raton)
Teaching Hospital (UPL Supplemental Payment Only)	
University of New Mexico Hospital	Bernalillo (Albuquerque)

Source: NMHPC


New Mexico Sole Community Provider Hospitals
San Juan Regional Medical Centers
Miners Colfax Medical Center
Holy Cross Hospital
Union County General Hospital
Los Alamos Medical Center
Española Hospital
Christus St. Vincent Hospital
Rehoboth McKinley Christian Hospital
Alta Vista Regional Medical Center
Cibola General Hospital
Dan C. Trigg
Guadalupe County
Plains Regional Medical Center – Clovis
Socorro General Hospital
Roosevelt General
Roswell Regional Hospital
Lincoln County Medical Center
Sierra Vista Hospital Sierra
Eastern New Mexico Medical Center
Nor-Lea General Hospital
Gerald Champion (Memorial)
Gila Regional Medical Center
Artesia General Hospital
Lea Regional Hospital
Mimbres Memorial Hospital
Memorial Medical Center
Carlsbad Medical Center
Mountain View Regional Medical Center
N
0
35
70
140
210
280
Miles
NM Sole Community Provider Hospitals
County Boundries
Created 11/28/11 By AM PSFA
Sources: US Census TIGER/Line Files &
New Mexico Human Services Department

Source: HSD

APPENDIX D: State Health Premium Tax Rates Ranked

Rank	State	Tax Rate	Notes
1	PA	9.99%	Corporate Income Tax Rate
2	DC	9.98%	Tax Based on Net Profits
3	ME	8.93%	Corporate Income Tax Rate
4	TN	5.50%	Premium Tax Rate
5	SC	5.00%	Corporate Income Tax Rate
5	LA	5.00%	Premium Tax Rate
7	HI	4.265%/2.75%	Premium Tax Rate
8	WV	4.00%/3.00%	Premium Tax Rate
8	**NM**	**4.00%**	Premium Tax Rate
9	NV	3.50%	Premium Tax Rate
10	MS	3.00%	Premium Tax Rate
11	MT	2.75%	Premium Tax Rate
12	AK	2.70%	Premium Tax Rate
13	SD	2.50%	Premium Tax Rate
13	AR	2.50%	Premium Tax Rate
14	CA	2.35%/0.50%	Premium Tax Rate
15	GA	2.25%	Premium Tax Rate
15	OK	2.25%	Premium Tax Rate
15	UT	2.25%	Premium Tax Rate
16	AZ	2.00%	Premium Tax Rate
16	MD	2.00%	Premium Tax Rate
16	NH	2.00%	Premium Tax Rate
16	NJ	2.00%	Premium Tax Rate
16	RI	2.00%	Premium Tax Rate
16	WA	2.00%	Premium Tax Rate
16	MA	2.00%	Premium Tax Rate
16	VT	2.00%	Premium Tax Rate
16	MN	2.00%	Premium Tax Rate
16	DE	2.00%	Premium Tax Rate
16	MO	2.00%	Premium Tax Rate
17	NC	1.90%	Premium Tax Rate
18	NY	1.75%/0.7%	Total Insurer Tax Liability is 7.96%
18	TX	1.75%	Premium Tax Rate
18	CT	1.75%	Premium Tax Rate
18	ND	1.75%	Premium Tax Rate
18	FL	1.75%	Premium Tax Rate
19	AL	1.60%	Premium Tax Rate
20	KY	1.50%	Premium Tax Rate
20	ID	1.50%	Premium Tax Rate
21	IN	1.30%	Premium Tax Rate
22	IA	1.00%	Premium Tax Rate
22	KS	1.00%	Premium Tax Rate
22	OH	1.00%	Premium Tax Rate
22	OR	1.00%	Premium Tax Rate
22	NE	1.00%/0.50%	Premium Tax Rate
23	WY	0.75%	Premium Tax Rate
24	IL	0.40%	Premium Tax Rate
25	VA	0.00%	
N/A	PR	Data Not Available	
N/A	CO	Fee Based on Premium Volume	
N/A	WI	Proportionate to Business Share	

Source: NAIC/Individual State Insurance Depts & Taxation and Revenue Depts

APPENDIX E: Summary of Rural Healthcare Practitioner Tax Credits in Other States

Alabama Rural Physician Tax Credit:

- Physicians
- Must practice and reside in communities of less than 25,000
- Must have admission privileges to small or rural hospital with emergency room – located more than 20 miles from another acute care hospital receiving Medicare rural reimbursement
- Credit is $5,000 per year
- Credit may be claimed for not more than five consecutive years

Georgia Rural Physicians Credit:

- Physicians licensed to practice medicine in Georgia
- Physician primarily admits patients to a rural hospital
- Physician practices in fields of family practice, obstetrics and gynecology, pediatrics, internal medicine or general surgery
- Must practice and reside in rural communities
- Must have admission privileges to small or rural hospital with emergency room – located more than 20 miles from another acute care hospital receiving Medicare rural reimbursement
- Credit is $5,000 per year
- Credit may be claimed for not more than five years
- No carryover or carry-back
- The credit cannot exceed the taxpayer's income tax liability

Louisiana Tax Credit for Physicians and Dentists

- Medical Doctor or Dentist
- Medical Doctor must practice within 20 miles of a community hospital not owned predominantly by other physicians. Both the hospital and office must be located more than 20 miles from the nearest incorporated city with a population in excess of 30,000
- Medical doctor shall have relocated from outside the service area of the hospital
- Credit: reduces tax by lesser of the tax due of $5,000 per year
- Credit: may be claimed for a maximum of 5 years
- Dentist must practice within an area designated a Dental Health Professional Shortage Area
- Dentist must agree to practice for not less than 3 years. The tax reduction shall continue to be available for two additional years.
- Practitioners must accept Medicaid and Medicare payments
- Credit available for only one relocation and only for a maximum of 5 years.

Oregon's rural practitioner state income tax credit

- Credit: Up to $5,000 income tax credit
- Partial year = pro-rated credit
- Eligible MDs, DOs, DPMs, NPs, PAs and CRNAs
- Must spend 60 percent or more of their practice in an eligible area of Oregon
- Eligible MDs, Dos, DPMs:
    - On the medical staff of rural hospital not in a Metropolitan Statistical Area (MSA),

    - On the medical staff of rural hospital in an MSA but is 30 or more highway miles from the major population center in the MSA,
    - On staff of a critical access hospital or
    - Not on staff of eligible hospital but practice deemed eligible by state
- Eligible NPs and PAs:
    - Practices are 60% or more “eligible
- Eligible CRNA:
    - Employed by, or have a contractual relationship with a qualifying Critical Access Hospital
- Once a practitioner is certified, the eligibility may be renewed each year if the practice site remains in an eligible area

APPENDIX F: Healthcare Tax Expenditure Summary

Healthcare Tax Expenditure Summary

Tax Expenditure	Foregone Revenue	Statute	Adopted	Description
Rural Practitioner Tax Credit	$6.7 million	7-2-18.22	2007	Provides a personal income tax credit to healthcare practitioners who provide services in rural underserved areas. The credit may be carried forward for 3 years if the credit exceeds tax liability. The maximum allowable credit for physicians, dentists, osteopathic physicians, clinical psychologists, podiatrists and optometrists is $5 thousand. The maximum allowable credit for dental hygienist, physician assistants, certified nurse-midwives, certified register nurse anesthetists, certified nurse practitioners or clinical nurse specialists is $3 thousand.
Pre-emption for Insurance Companies	$83.7 million	59fA-6-6; 7-9-24	1969	Under the premium tax statute, health insurers pay 4 percent tax on gross premiums received from their insured in lieu of paying other taxes.
NMMIP Assessment Deduction	$49.6 million	59A-54-10	1978	Provides a premium tax credit for health insurers who pay assessments to the New Mexico Medical Insurance Pool (NMMIP). Credits are 50% of the assessed amount for most members and 75% of the assessed amount attributable to special risk groups (HIV, hemophilia, medically fragile children).
Deduction for Medical Service Providers	$50 million	7-9-93	2004	Removes the GRT tax from certain healthcare services. Provides a deduction for receipts of licensed health practitioners from payments by a managed care provider for Medicare Part C services or commercial contract services.
Hospital GRT Tax Expenditure	$12.5 million	7-9-96.1	2007	As of FY12 for-profit hospitals pay no state GRT and a local GRT liability of approximately 1 percent.

APPENDIX G: County-Supported Medicaid Dollars per Recipient

County	County-Supported Medicaid Dollars (FY11)	Medicaid Recipients
Bernalillo	$10,276,245	141,223
Catron	$15,856	486
Chaves	$790,831	20,167
Cibola	$157,844	8,418
Colfax	$142,394	2,783
Curry	$560,964	13,057
DeBaca	$12,060	498
Doña Ana	$2,237,227	65,578
Eddy	$1,122,453	13,569
Grant	$307,673	7,186
Guadalupe	$47,107	1,268
Harding	$8,687	78
Hidalgo	$35,520	1,277
Lea	$1,429,546	15,441
Lincoln	$229,268	4,270
Los Alamos	$830,142	497
Luna	$214,853	9,093
McKinley	$739,566	29,878
Mora	$14,617	1,319
Otero	$425,200	11,328
Quay	$87,398	2,699
Rio Arriba	$301,088	13,637
Roosevelt	$123,965	4,940
Sandoval	$820,048	24,921
San Juan	$1,824,536	34,739
San Miguel	$231,451	8,686
Santa Fe	$2,000,623	23,507
Sierra	$104,103	3,258
Socorro	$129,020	5,203
Taos	$413,070	7,917
Torrance	$134,401	5,916
Union	$57,887	777
Valencia	$461,230	20,203
Total	**$26,286,873**	**503,817**

APPENDIX H: Health Policy Commission Recruitment Recommendations

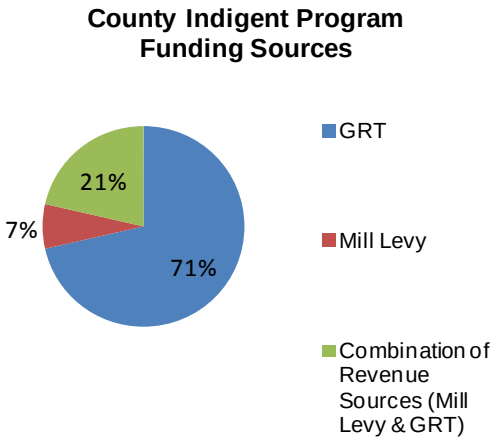
In its January 2011 report, Recommendations to Address New Mexico Healthcare Workforce Shortages, the New Mexico Health Policy Commission recommended twelve strategies:

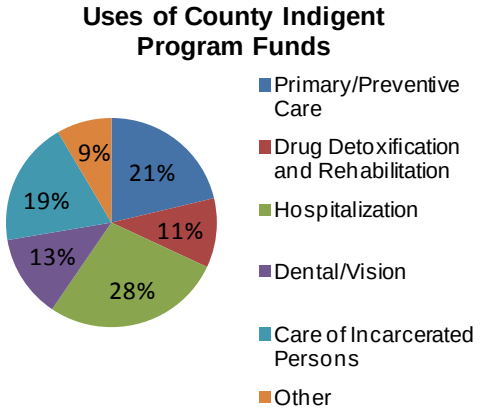
1. Expand New Mexico Health Services Corps to provide additional stipends and community contracts to encourage rural practice
2. Expand the New Mexico Health Professional Loan Repayment Program
3. Expand the New Mexico Loan-for-Service Program
4. Establish a Primary Care Physician conditional tuition 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 Nurse Practitioners and Physician Assistants who agree to work in NM for 3 years
10. Create a state entity to coordinate health professional workforce needs and efforts
11. Support the DOH as it implements SB14 to track the health workforce
12. Expand New Mexico mid-level provider training programs

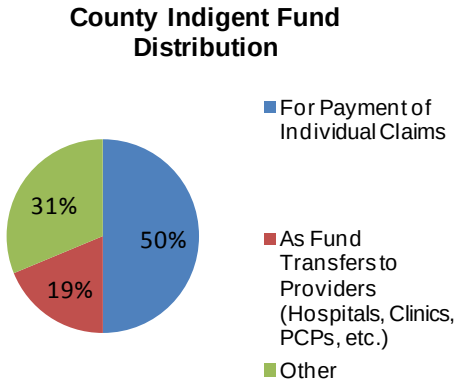
APPENDIX I: Sole Community Provider Hospital Base and UPL Supplemental Payments FY09-FY11

		FY09			FY10			FY11		
Hospital	Counties Contributing to SCP	County Dollars	Federal Match Dollars	Total	County Dollars	Federal Match Dollars	Total	County Dollars	Federal Match Dollars	Total
Artesia General	Eddy	$304,849	$816,768	$1,121,617	$374,371	$1,313,683	$1,688,054	$280,153	$942,166	$1,222,319
Carlsbad Medical Center	Eddy	$1,454,507	$3,995,187	$5,449,695	$1,457,026	$4,984,353	$6,441,378	$976,026	$2,836,659	$3,714,685
Cibola General	Cibola	$1,268,049	$3,589,830	$4,857,878	$1,396,659	$4,821,186	$6,217,845	$1,855,216	$6,161,324	$8,016,540
Dan C. Trigg Memorial	Quay	$741,309	$2,073,697	$2,815,006	$804,483	$2,775,034	$3,579,517	$1,093,126	$3,650,561	$4,743,687
Eastern NM Medical	Chaves, Eddy	$5,023,428	$14,240,532	$19,263,960	$5,434,016	$18,714,892	$24,148,908	$3,697,984	$12,826,785	$16,524,769
Espanola Hospital	Rio Arriba, Santa Fe, Los Alamos, Taos	$1,006,368	$2,784,770	$3,791,137	$833,388	$2,896,570	$3,729,957	$845,492	$2,969,325	$3,814,817
Gerald Champion	Otero	$656,651	$1,914,418	$2,571,069	$840,846	$2,944,420	$3,785,266	$868,648	$3,050,963	$3,919,611
Gila Regional	Grant, Luna, Hidalgo	$2,571,252	$7,265,802	$9,837,054	$2,721,844	$9,392,009	$12,113,853	$3,541,998	$11,705,012	$15,247,009
Guadalupe County	Guadalupe	$1,098,399	$2,711,007	$3,809,405	$971,598	$3,302,884	$4,274,582	$1,194,378	$3,901,440	$5,095,817
Holy Cross	Taos, Colfax, Santa Fe	$1,722,147	$4,870,490	$6,592,636	$1,837,392	$6,318,677	$8,156,070	$2,295,405	$7,512,111	$9,807,516
Lea Regional	Lea	$1,544,356	$4,410,832	$5,955,188	$1,608,453	$5,509,582	$7,118,035	$1,590,306	$5,279,485	$6,869,791
Lincoln County	Lincoln	$663,421	$1,862,424	$2,525,845	$648,502	$2,271,726	$2,920,228	$745,217	$2,596,021	$3,341,237
Los Alamos	Rio Arriba, Santa Fe, Los Alamos, Taos	$206,867	$585,632	$792,499	$205,446	$709,862	$915,309	$190,196	$650,101	$840,297
Memorial Medical	Dona Ana, Grant, Hidalgo, Luna	$8,625,980	$25,100,277	$33,726,257	$8,595,219	$28,995,295	$37,590,514	$9,474,941	$30,088,087	$39,563,028
Mimbres Memorial	Luna	$809,641	$2,309,314	$3,118,955	$739,808	$2,543,682	$3,283,490	$759,795	$2,543,474	$3,303,270
Miner's Colfax	Colfax	$84,474	$244,498	$328,972	$80,168	$271,369	$351,537	$207,435	$773,370	$980,805
Mountain View	Dona Ana	$648,600	$1,863,432	$2,512,032	$1,433,740	$5,352,524	$6,786,265	$340,640	$1,153,480	$1,494,120
Alta Vista Regional	San Miguel	$649,486	$1,893,527	$2,543,013	$211,130	$710,433	$921,563	$122,586	$386,704	$509,291
Nor-Lea General Hospital	Lea	$143,950	$412,026	$555,976	$195,260	$688,611	$883,871	$351,953	$1,239,848	$1,591,801
Plains Regional Med. Clovis	Curry	$550,076	$1,555,570	$2,105,646	$775,913	$2,748,644	$3,524,557	$920,398	$3,150,583	$4,070,982
Rehoboth-McKinley	McKinley	$1,801,230	$4,984,276	$6,785,506	$1,887,472	$6,707,152	$8,594,624	$2,097,945	$7,107,964	$9,205,910
Roosevelt General Hospital	Roosevelt	$505,973	$1,387,938	$1,893,911	$586,232	$2,036,961	$2,622,194	$736,580	$2,409,394	$3,145,974
Roswell Regional Hospital	Chaves	$0	$0	$0	$0	$0	$0	$316,986	$1,268,310	$1,585,296
St. Vincent Hospital	Santa Fe, Taos, San Miguel, Rio Arriba, Los Alamos, Luna	$9,167,772	$26,463,220	$35,630,992	$8,025,600	$27,242,372	$35,267,972	$6,560,740	$22,156,898	$28,717,638
San Juan Regional	San Juan	$4,680,788	$13,300,104	$17,980,893	$4,945,491	$16,979,257	$21,924,748	$6,182,550	$20,243,836	$26,426,386
Sierra Vista Hospital	Sierra	$760,450	$2,112,427	$2,872,877	$793,878	$2,754,800	$3,548,678	$931,188	$3,170,516	$4,101,704
Socorro General	Socorro	$918,553	$2,599,342	$3,517,895	$868,964	$3,007,474	$3,876,438	$831,099	$2,871,544	$3,702,644
Union County General	Union	$609,314	$1,716,972	$2,326,285	$659,957	$2,274,487	$2,934,444	$813,143	$2,672,324	$3,485,467
TOTAL		$48,217,889	$137,064,311	$185,282,200	$48,841,857	$168,268,041	$217,109,898	$49,724,125	$165,318,285	$215,042,411

APPENDIX J: LFC Survey Data of County Indigent Program Funding and Payment Activity

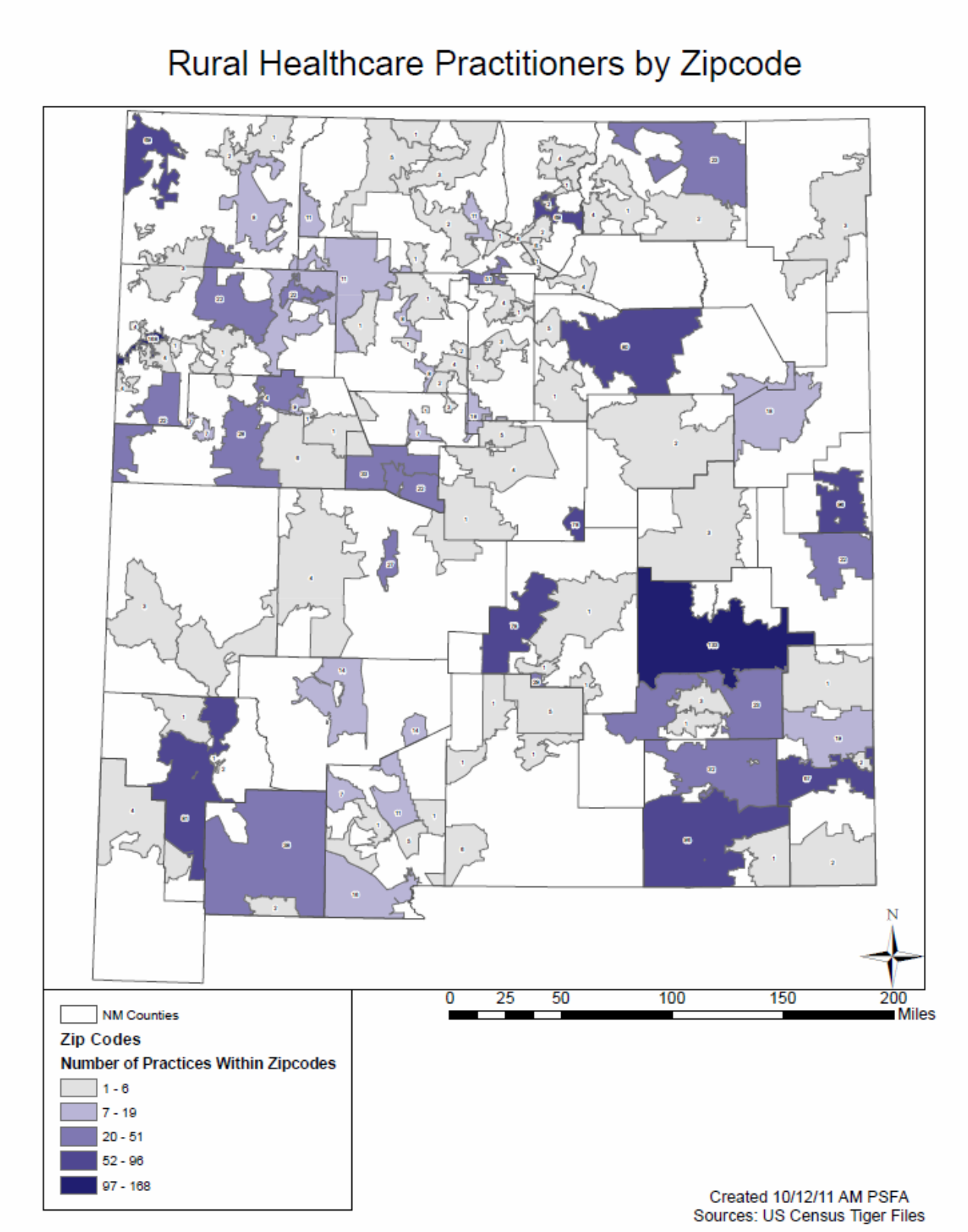






Source: LFC Survey of Counties

Note: 17 of 33 counties responded to LFC survey. Counties responding were McKinley, Union, Otero, Sierra, Lincoln, Colfax, Chaves, Quay, Roosevelt, Torrance, Guadalupe, Curry, Rio Arriba, Harding, San Juan, Hidalgo, Eddy,



Data Source: DOH