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Interim Health and Human Services Committee
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There are 31 codified chapters in New Mexico statutes of health-care or health-related professions. That's with Veterinary Care omitted from the list.

This memo will not seek to address all these professions, nor does it include a couple important topics at this time: medical malpractice and credential and licensing. I will supplement this memo in the next week or so. This memo is the result of a number of interviews and conversations I've had with various individuals, and reports I've reviewed since our July meeting. The work is not done. I have more interviews scheduled. Much data needs to be gathered.

Health care recruiter Jerry Harrison (JH) reports that among the physician specialties, only four currently are not underserved in New Mexico: ophthalmology, anesthesiology, radiology, and pathology. While there may not be critical shortages in all of the remaining 27 statutorily-defined disciplines (many are aka "allied specialties"), there appear to be substantial if not critical shortages in many of those most important to the health and well-being of New Mexicans.

It's possible that virtually everyone in the state has a tale of not being able to access an appropriate health care provider when they needed the care and/or at a price they could afford. On August 7, the Albuquerque *Journal* asked readers *How has your experience accessing preventive health care changed since the COVID-19 pandemic began?* They printed 11 responses. Only one thought access to preventive care was easier. Those who had telehealth visits generally found them better than no care, but not a good substitute for in-person services. Not a scientific sampling, but informative nevertheless.

This **preliminary** paper will look at three primary issues:

1. Why do we have substantial shortages in so many health care professions?
2. Given that there are essentially only three solutions to the problem: train more health-care professionals in-state, recruit trained health -care professionals from out-of-state (or outside the country), and/or encourage current health care providers in New Mexico to work longer, more efficiently, etc., what are our best options?
3. What are and how do we remove barriers to training/recruitment/and/or retention or, put another way, what are and how do we incentivize training/recruitment/and/or retention?

The causes of our provider shortages are many:

- The financing of health care is a literal morass of complex federal and state statutes and insurance company practices and procedures. In NM, because of the high percentage of New Mexicans who receive their healthcare through Medicaid (and to some extent Medicare), our health care providers often earn less than they could earn in other parts of the country. According to JH, pay is the first question possible new hires ask about. *He and others emphasize that we are not just competing with surrounding states, but with the entire country in attracting health care providers.*

- The disparity between hospital reimbursements for procedures and the reimbursements provided to private practices for the same procedures seems to serve as a disincentive to private practitioners.

- Health care is replete with licensing requirements, certifications, boards, commissions, and insurance companies, some of which result in delaying health care workers to be able to do the jobs they've trained for. While changes were made to our licensing statutes in 2022 do we need to consider more changes and/or better implementation? *This topic will be addressed in a subsequent memo.*

- The rigor and high cost of much (all?) health-career training. It simply is not easy to turn on a spigot and quickly produce substantial numbers of new practitioners. Additionally the national limitations on the number of residencies for physicians arguably artificially limits the number of physicians in the country and our state.

- The difficulty of the work itself, which "burns out" many providers at relatively young ages. New Mexico has the oldest and fewest percentage of physicians under 40. Many retire at 60. Women physicians often leave the work force at 40 to 45. In terms of recruitment, physicians particularly are asking how much "call" they're going to be required to do. (JH)

- The impact of New Mexico's medical malpractice laws affecting or potentially affecting the availability and/or cost of malpractice coverage and perhaps creating an overly-litigious environment.

- The impact of hospitals or lack of hospitals.

- The dispersed population and physical size of New Mexico

- In the area of behavioral health specifically, the closure by the prior administration of a substantial number of behavioral health providers for alleged billing fraud which decimated this provider base; the high demand and need for these services as reflected in the rate of New Mexicans who are addicted to alcohol and/or drugs; and the number of NM families and children at risk of abuse or neglect reflected in high caseloads for

CYFD staff and high demand by the agency for behavioral health professionals, particularly social workers.

The remainder of this initial paper will be to share some preliminary information focused on those areas where either legislation or funding could make a difference in the number of our health care providers serving our population and the health of our health care system.

My focus in my initial work has been in the fields of nursing, physicians and behavioral health. I have additional meetings set up (and more to set up). I want to emphasize that this is a PRELIMINARY paper. I have requests in to various state agencies for real data relating to various state initiatives and programs, without which it is difficult to judge what is working and what is not working.

I. PRELIMINARY SUGGESTIONS

<u>Data Analysis re Health-Care Providers</u>

There is concern about the accuracy of Dr. Larsen's data regarding our health-care workforce. The concern is based upon the following: (1) his figures reflect the number of "licensed" individuals, rather than the number actually practicing; and (2) his numbers include providers employed for specific populations, i.e. IHS and VA populations. While providing health care to these populations is important, these practitioners may not be available to serve the general populations in the areas where they are located.

These comments are not intended as a criticism of Dr. Larsen. My understanding is that the survey was originally housed at UNMHSC as sort of a stopgap measure and has never received appropriate funding. Some of the suggestions for improvement are that it be revised to reflect supply/demand and input/output analysis along with salary surveys for healthcare providers and an interactive virtual database. An accurate survey would seem to be basic "infrastructure" data for health-care planning and policy choices. Or put more simply, you can't manage what you don't (accurately) measure.

<u>Workforce Strategic Plan</u>

The lack of a statewide strategic plan in behavioral health services was discussed in our behavioral session and was included in our list of recommendations. A similar recommendation – this time focused on a strategic plan which looks at all the health care disciplines and takes an integrated, collaborative approach to the issue of having a sufficient number of qualified health care providers in the various disciplines -- has been suggested. In terms of legislation, it may be appropriate to designate DOH and HSD to collaboratively lead this effort, including other relevant stakeholders at the table such as CYFD, DVS, RLD, OIS, advocacy organizations, etc. We need to get rid of the silos.

<u>Financial Considerations & Proposals</u>

1. **Health Trust Fund.** Creation of an Expendable Trust Fund for Health Care – Modeled after the early childhood trust fund, the Healthcare Trust Fund (called HTF here for simplicity) could be created with a portion of the general fund surpluses now available and projected to be available, sustained by (1) an earmark of a portion of tax revenues generated by healthcare businesses including the healthcare premium surtax, (2) revenues from any loan programs offered through the trust for healthcare facility and equipment capital projects or other enterprise programs or services; (3) investment and interest income from the HTF corpus. The HTF would be available to fund healthcare capital outlay projects, equipment, workforce training, recruitment and retention programs; enhancement of healthcare services such as provider reimbursements, premium assistance, etc. The legislature would create the programs and appropriate the money.

2. **Taxation.** The current laws relating to the state taxation of health care providers and services is disorganized and inconsistent among the various disciplines. We should at least fund a study of the current state tax structure for healthcare services and entities to identify changes in the GRT, income tax credits, rebates and deductions that would create a tax system that is consistent, effective, and fair to the various healthcare disciplines, that appropriately incentivizes the delivery of health care in New Mexico with priorities established by the legislature and strategic master plan, and that is consistent with the revenue needs of the state.

   In addition, we should ask Tax and Rev for data to determine the extent to which the various income tax credits granted to rural health care workers are being used. It seems like every year this is a bill to expand the provider fields that would qualify for these benefits but the bill usually does not get passed. There may be some issue between whether Tax and Rev or DOH should have regulatory authority. If this tax credit program is effective in helping us retain health care professionals in shortage areas, we should be able to sort out the agency dispute, shouldn't we?

   Are these tax credits sufficient in amount and/or criteria? For example, physicians who work in shortage areas may claim a $5000 tax credit if they provide at least 2,080 hours of health care services in the tax year. No vacation time or sick leave allowed?

   Should tax credits be available, not just to individual practitioners, but to independently owned practices that may operate as a PC or other entity-form of business?

3. **Expanding Clinic Training Support and Venues.** UNM has some 560 medical residents and a program called 1+2. The first year of residency is at UNM and the last two years are in hospitals or other health facilities around the state. The problem is that a residency requires *clinical supervision* and there is a real lack of *preceptors* to provide

this supervision outside of Albuquerque and perhaps other urban areas. The preceptors are usually physicians in practice who are doing this important work on their own time.

The same problem is happening in nursing which also requires clinical supervision as part of the required training. There may be other fields where this is also true. The proposal is for the state to fund these preceptors around the state where clinical training is occurring as part of the required training and there are no paid individuals to provide it. **The benefit is huge: students who train in these communities often will stay in those communities.** Additionally, in some fields like nursing and perhaps for physicians, the clinical venues should be expanded to include nursing homes, clinics, birthing centers, rehab centers and other health-care facilities.

4. **Loans and Repayments.** The following ideas relate to financing (loans) and assistance with repaying loan or other financial benefit incentives to health care providers:

    A. There are a number of federal and state programs to assist health care students to pay for their educations and/or to then repay the loans that helped them pay for their educations. I counted six or seven programs in the materials JH provided me, which are primarily state-funded or primarily loan programs. Virtually all of these require that the recipients agree to practice in shortage areas for a period of time. The most “generous” program provides loans up to $25,000 annually for students with demonstrated financial need enrolled at the UNM School of Medicine).
    Data has been requested from the Higher Education Department relating to the loan (and loan repayment) programs.

    B. In terms of recruiting health professionals from out of state, JH says **loan repayment** programs are really important. There are several federal repayment programs. On the state side, the major program is the NM Health Professional Loan Repayment Program (NMHPLRP) which offers up to $30,000 per year in return for a two-year commitment to serve in shortage areas. Preference is given to graduates of NM public post-secondary institutions. This program had some 600 applications this year and 40 were funded from $1.6 million in state funding and another 10 with federal funding. The average total student loan debt for medical school graduates is $241,600. For dentists, it’s reportedly $700,000. Perhaps consideration should be given to increasing the amount of the repayment.

    C. **Loan Program for Setting up Practices** – Last session I sponsored at the request of the Medical Society HB97 which would have established a $7.5 million revolving loan fund for loans of up to $500,000 for health care providers wanting to set up practices in shortage areas. The MFA would have

been the administrator. The bill didn't get on the funding track quickly enough in 2022 but will be reintroduced in 2023. Health care providers are vital economic development engines for shortage areas.

Just Asking -- Would NM be better off with more funding for a smaller number of programs – loans and/or repayment/tax credits – than adding more programs that are likely to be added to the underfunded list? Would the HTF described above be a possible funding source?

Just Asking? -- **Can we increase Medicaid reimbursements rates?** One way to possibly increase health-care provider incomes – and thus increase our competitiveness -- is to increase Medicaid provider rates. At the very least shouldn't we be asking some hard questions about how to maximize income increases to providers when Medicaid funding is increased?

5. **Credentialing and Licensing** Changes were made in the 2022 legislature to the licensing and credentialing statutes. I will supplement this memo after reviewing those changes. I would note that because of delays in credentialing, physicians are often unable to start a practice because they have no income for a substantial period of time. If they go to work for a hospital, the hospital will arrange for the credentialing and they are able to begin work and earn income. Should we consider an "any willing provider" statute?

6. **Pipelines at the high school level** -- Hiland High School, Rio Rancho High School and Deming High School all have "pipeline" programs to encourage students to go into health-care field. A federal study has indicated these do not work very well. Better use of funds is to increase loan repayment program?

7. NOTE: It will be interesting to see what impact, if any, the Governor's new free-tuition act that we passed this past session will have on the demand for loans.

II. **IDEAS FROM THE THREE DAYS OF HEARINGS** (thanks to co-chair Senator Ortiz y Pino for sharing his meeting notes).

1. A $25 million fund to assist agencies in hard-to-recruit areas attract more providers. Could cover relocation, housing, tuition reimbursement and even signing bonuses.
(Not from the July hearings, but nurses are making a similar request to assist students with transportation and lodging when involved in clinical placements outside their home residences.)

2. Immediately expand the capacity of agencies by permitting (or actually financing) the reimbursement for work done by interns; paying those interns to assist them in completing the work needed to secure licensure; paying for the staff time it takes to supervise and mentor the interns. *I remember some discussion about this at the meetings at UNM but do not recall details about which fields this involved though it may have been behavioral health. Further information needed. I don't recall any discussion of where the funding would come from. Paid internships would seem to be much better than unpaid in motivating people.*

3. Making the behavioral health field attractive for graduate work by expanding tuition-free education to the master's level behavioral health programs at all (*public?*) NM colleges and universities.

4. Expanding the use of Project ECHO to upgrade the skills of the entire spectrum of BH and Substance disorder treatment providers: peer counselors, community health workers, LADACs, counselors, psychologists, social workers, psychiatric nurses and psychiatrists. The idea is that this would make existing numbers of providers able to reach more patients in a more effective manner.

5. Streamline the licensing of out-of-state professionals relocating to NM; reduce the barriers to their joining HMO networks; possibly turn decision-making about entering interstate compacts over to the appropriate professional board rather than leaving it in the hands of the legislature. *As noted above, I will be updating this document with more information about credentialing and licensing.*

6. Work with MFA on financing housing for Behavioral Health professionals as both another incentive and as a way for rural communities to attract professionals to work there. Some districts do that now with school teachers; other communities help police and other first responders with housing assistance. (*Question: Aren't these programs primarily for relatively lower-income individuals who can't afford housing in pricy communities like Santa Fe? Are health care workers in the same situation?)*

7. Fund positions in key departments to actively recruit BH professionals rather than waiting for them to show up on their own. (*Note: I have just received a copy of a draft of the CYFD workforce plan which may well include an active recruitment strategy. I've not had a chance to review it yet. CYFD appears to be a major player in behavioral workforce issues and -- something I didn't know until last week – has responsibility for all behavioral health services provided to children in New Mexico whether or not they're involved with CYFD.)*