THINK NEW MEXICO

A Results-Oriented Think Tank Serving New Mexicans

25TH ANNIVERSARY

— 1999 – 2024 —

HOW TO SOLVE NEW MEXICO'S HEALTH CARE WORKER SHORTAGE

Cover Art:	Charlie McCarty
Design:	Kristina G. Fisher
Design Consultant:	Arlyn Eve Nathan
Pre-Press:	Peter Ellzey
Production Manager:	Susan Martin
Researched by:	Kristina G. Fisher, Fred Nathan, Jr., Dr. Alfredo Vigil, Elizabeth Farrington, Jules Hanisee, Laurel Nash Jarecki, Alex Schweitzer Kroll, Tanya Ruiz Parra, Joaquin Romero, Jesus Eduardo Sanchez, Andrew Schumann, Nathan Slota, and Ayvret van Waveren
Written by:	Fred Nathan, Jr. and Kristina G. Fisher

The paper used to print this report has been certified as sustainably sourced.

Think New Mexico began its operations on January 1, 1999. It is a tax-exempt organization under section 501(c)(3) of the Internal Revenue Code. In order to maintain its independence, Think New Mexico does not accept government funding. However, contributions from individuals, businesses, and foundations are welcomed, encouraged, and tax-deductible.

To receive additional copies of this or any other Think New Mexico report, please provide us with your name, address, telephone number and $10.00 per copy. An order form is available on our website at www.thinknewmexico.org. Please allow two weeks for shipping and handling.

THINK NEW MEXICO

A Results-Oriented Think Tank Serving New Mexicans

Address: 505 Don Gaspar Ave.
Santa Fe, New Mexico 87505
Telephone: 505. 992.1315
Fax: 505. 992.1314
Email: info@thinknewmexico.org
Web: www.thinknewmexico.org

About Think New Mexico

Think New Mexico is a results-oriented think tank whose mission is to improve the quality of life for all New Mexicans, especially those who lack a strong voice in the political process. We fulfill this mission by educating the public, the media, and policymakers about some of the most serious challenges facing New Mexico and by developing and advocating for enduring, effective, evidence-based solutions to overcome those challenges.

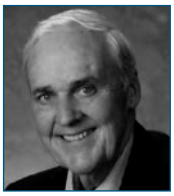
Our approach is to perform and publish sound, nonpartisan, independent research. Unlike many think tanks, Think New Mexico does not subscribe to any particular ideology. Instead, because New Mexico is at or near the bottom of so many national rankings, our focus is on promoting workable solutions that will lift New Mexico up.

Results

As a results-oriented think tank, Think New Mexico measures its success based on changes in law we help to achieve. Our results include:

- Making full-day kindergarten accessible to every child in New Mexico
- Repealing the state's regressive tax on food and defeating attempts to reimpose it
- Creating a Strategic Water Reserve to protect and restore the state's rivers
- Redirecting millions of dollars a year out of the state lottery's excessive operating costs and into college scholarships
- Establishing New Mexico's first state-supported Individual Development Accounts to alleviate the state's persistent poverty
- Reforming title insurance to lower closing costs for homebuyers and homeowners who refinance their mortgages
- Streamlining & professionalizing the Public Regulation Commission
- Creating a one-stop online portal to facilitate business fees and filings
- Establishing a user-friendly health care transparency website where New Mexicans can find the cost and quality of common medical procedures
- Enacting the New Mexico Work and Save Act to expand access to voluntary state-sponsored retirement savings accounts for private sector workers
- Making the state's infrastructure spending transparent by revealing the legislative sponsors of every capital project
- Ending predatory lending by reducing the maximum annual interest rate on small loans from 175% to 36%
- Repealing the tax on Social Security for middle and lower income New Mexicans
- Adding financial literacy to the state's education standards
- Enhancing the training and transparency of local school boards

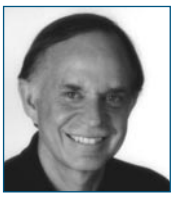
Think New Mexico's Board of Directors



Phelps Anderson served four terms in the New Mexico House, 1977–1980 and 2019–2022. A businessman from Roswell, Phelps has worked in industries ranging from ranching to restaurant management, and he is the president of SunValley Energy Corp. Phelps chaired the Interstate Stream Commission and serves on the board of regents of the New Mexico Military Institute.

Clara Apodaca, a native of Las Cruces, was First Lady of New Mexico from 1975–1979. She served as New Mexico's Secretary of Cultural Affairs under Governors Toney Anaya and Garrey Carruthers and as senior advisor to the U.S. Department of the Treasury. Clara is the former President and CEO of the National Hispanic Cultural Center Foundation.

Jacqueline Baca has been President of Bueno Foods since 1986. Jackie was a founding board member of Accion and has served on the boards of the Albuquerque Hispano Chamber of Commerce, the New Mexico Family Business Alliance, and WESST. In 2019, she was appointed to the Federal Reserve Bank of Kansas City's Denver Branch Board of Directors.



Paul Bardacke served as Attorney General of New Mexico from 1983–1986. He is a Fellow in the American College of Trial Lawyers, and he handled complex commercial litigation and mediation with the firm of Bardacke Allison in Santa Fe. Paul was a member of the National Park System Advisory Board for seven years.

Notah Begay III, Navajo/San Felipe/Isleta Pueblo, is the only full-blooded Native American to have played on the PGA Tour, where he won four tournaments. He now works with Native communities to develop world-class golf properties. Notah founded The Notah Begay III Foundation (NB3F), which works to reduce obesity and diabetes among Native American youth.

Garrey Carruthers served as Governor of New Mexico from 1987–1990 and as Chancellor of the system and President of New Mexico State University from 2013–2018. In between he served as Dean of the College of Business at NMSU and as President and CEO of Cimarron Health Plan. Garrey was instrumental in establishing the Arrowhead Center for economic development in Las Cruces.

LaDonna Harris is Founder and Chair of the Board of Americans for Indian Opportunity. She is also a founder of the National Women's Political Caucus. LaDonna was a leader in the effort to return the Taos Blue Lake to Taos Pueblo. She is an enrolled member of the Comanche Nation.

Edward Lujan is a 19th generation New Mexican and the former CEO of Manuel Lujan Agencies, the largest privately owned insurance agency in New Mexico. Ed is also a former Chairman of the Republican Party of New Mexico, the New Mexico Economic Development Commission, and the National Hispanic Cultural Center of New Mexico, where he is now Chair Emeritus.

Liddie Martinez is a native of Española whose family has lived in northern New Mexico since the 1600s. Liddie is the Market President - Los Alamos for Enterprise Bank and Trust, and a past Board Chair of the Los Alamos National Laboratory Foundation. She also farms the Rancho Faisan. Liddie served on Governor Michelle Lujan Grisham's Economic Recovery Council.

Judith K. Nakamura was a member of the New Mexico judiciary from 1998–2020. She was appointed to the New Mexico Supreme Court in 2015, and in 2017, she became only the fourth woman to serve as Chief Justice in the Court's 108-year history. Judy is an avid hot air balloon pilot and she serves on the board of the Albuquerque International Balloon Fiesta.

Fred Nathan, Jr. founded Think New Mexico and is its Executive Director. Fred served as Special Counsel to New Mexico Attorney General Tom Udall from 1991–1998. In that capacity, he was the architect of several successful legislative initiatives and was in charge of New Mexico's lawsuit against the tobacco industry, which resulted in a $1.25 billion settlement for the state.

Roberta Cooper Ramo is the first woman elected President of the American Bar Association and the American Law Institute. Roberta has served on the State Board of Finance and was President of the University of New Mexico Board of Regents. In 2011, she was inducted into the American Academy of Arts and Sciences. Roberta is a shareholder in the Modrall Sperling law firm.

Dear New Mexican:

THINK NEW MEXICO'S STAFF

Kristina G. Fisher
Associate Director

Katie Gutierrez
Tax, Budget & Economic Development Reform Director

Marcus Lujan
Field Director

Susan Martin
Business Manager

For most of the quarter-century of Think New Mexico's existence, our policy reports have generally proposed a single core recommendation, like making full-day kindergarten accessible to every child in the state or ending predatory lending.

This year's policy report, like our 2022 policy report, titled *A Roadmap for Rethinking Public Education in New Mexico*, is broader in scope and makes a series of recommendations focused on a key challenge facing the state. It is the product of two years of research and presents a ten point plan with 20 commonsense legislative recommendations designed to alleviate New Mexico's health care worker shortage.

As the baby boomer population in New Mexico ages and the demand for medical services soars, this shortage has become a full-blown crisis, as any New Mexican who has tried to get a medical appointment recently can attest.

In this report we propose both an agenda of reforms and a responsible way to pay for them without raising taxes or cutting other spending. Although many of the reforms will require a long-term investment from the new permanent fund we propose, it is hard to overstate the potential costs of failing to reform the system. That cost is measured in both the physical health of New Mexicans and the economic health of the state.

We have no illusions that this crisis can be solved quickly. As such, we regard this as a multi-year effort and we are committed to seeing all of our recommendations through to enactment.

As part of that commitment, we hired Dr. Alfredo Vigil to be our inaugural Healthcare Reform Director. Alfredo is a former Secretary of the New Mexico Department of Health and has a deep understanding of the health challenges facing New Mexico communities, especially in rural parts of the state.

Alfredo is uniquely qualified for this work. He attended public schools in Los Alamos and earned his Bachelor of Science and M.D. from the University of New Mexico. Along with working as a primary care physician in private practice, Alfredo has served as the Medical Director of the Questa Health Center, Chief of Staff of Holy Cross Hospital in Taos, and

the CEO of El Centro Family Health in Espanola. Alfredo has also helped train the next generation of doctors as a member of the Clinical Faculty at the UNM School of Medicine.

New Mexico has many assets to build upon in addressing the challenge of the health care worker shortage. For example, New Mexico is fortunate to have groups like Project ECHO, which provides enormously impactful telementoring services to health care practitioners, expanding the capacity and uplifting the quality of care throughout the state. We also want to acknowledge the important and often thankless work being done by groups like New Mexico Health Resources, which recruits health care professionals to the state, and the New Mexico Department of Health's Office of Primary Care & Rural Health, which administers programs including the Health Professional Loan Repayment Program and the Rural Health Practitioner Tax Credit, among others.

We want to thank all of the various experts to whom we spoke and who shared their knowledge and perspectives with us. And a special thanks to two impactful New Mexico foundations, Anchorum Health Foundation and Con Alma Health Foundation, which provided financial support and thoughtful insights into the health care worker shortage.

If you would like to be part of this effort to solve New Mexico's health care worker shortage, please visit our website at www.thinknewmexico.org, where you can sign up for email updates on our progress and contact your legislators and the governor to express your opinion.

In our 25-year history, Think New Mexico has never employed an advancement director or held an in-person fundraising event. We depend on the quality or our work and the faithful generosity of supporters like you to attract and retain our top-notch staff and to keep the lights on. So please consider this letter your invitation to join the more than 1,200 supporters who invest in Think New Mexico's work by making a contribution online or in the yellow reply envelope you will find enclosed in this report.

Fred Nathan Jr.

Founder and Executive Director

Fred Nathan, Jr.
Executive Director

Mandi Torrez
Education Reform Director

Alfredo Vigil, MD
Healthcare Reform Director

INDEX OF RECOMMENDED REFORMS:

How to Solve New Mexico's Health Care Worker Shortage

pages 14–23

Reform New Mexico's Medical Malpractice Act

- Cap Attorney's Fees
- End Lump-Sum Payouts from the Patient Compensation Fund
- Stop Venue Shopping
- Raise the Legal Standard for Punitive Damages and Cap Them
- Prohibit Lawyers from Filing Multiple Lawsuits Over a Single Malpractice Incident
- Require that Damages Awarded for Future Medical Costs Reflect the Actual Cost of Care

pages 24–26

Join All Ten Major Interstate Health Care Worker Compacts

pages 27–29

Create a Centralized Credentialing System

pages 30–32

Expand the Health Professional Student Loan Repayment Program

pages 33–35

Make New Mexico's Tax Policy More Friendly to Health Care Workers

- Permanently Repeal New Mexico's Gross Receipts Tax on Medical Services
- Increase and Expand the Rural Health Care Practitioner Tax Credit

pages 36–40

Enhance Medicaid Reimbursement & Reduce Claim Denial Rates

- Continue to Increase Medicaid Reimbursement Rates
- Require that a Significant Portion of Increased Rates go to Health Care Professional Salaries
- Require Automatic Reviews of Medicaid Claim Denials

pages 41–43

Grow More of Our Own Health Care Workers I: High School

- Provide Liability Protections for Health Care Employers Who Work with Students
- Revise CTE Pathways So That More Students Earn Health Care Credentials in High School

pages 44–46

Grow More of Our Own Health Care Workers II: Higher Education

- Make Higher Education Health Care Faculty Salaries More Competitive
- Provide a Tax Credit for Preceptors who Train Health Care Workers

pages 47–48

Import More International Medical Graduates

- Allow International Doctors to Apply for a Provisional License to Practice in New Mexico

pages 49–51

Establish a $2 Billion Permanent Fund for Health Care to Fund These Reforms

INTRODUCTION: THE HEALTH CARE WORKER SHORTAGE CRISIS

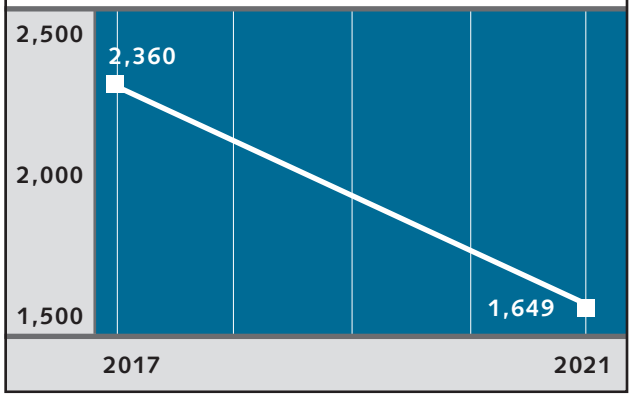
In March of 2016, with just six days' notice to patients, the Alta Vista Regional Hospital in Las Vegas, New Mexico closed its labor and delivery department. Pregnant women in the Las Vegas area suddenly had to travel over an hour away, to Santa Fe or Raton, to access prenatal and birthing care.

The reason for the closure was a lack of health care workers. As the Alta Vista CEO explained, "We simply have not been able to recruit and retain the clinical professionals necessary to maintain the program. To appropriately staff and operate a labor and delivery service in a hospital, at least two obstetrician-gynecologists and approximately 10 OB nurses are required, as well as two additional pediatricians. Despite our best efforts over the last year, we have not been able to attract the necessary clinical talent."

Desiree Castillo, who was pregnant with her second child at the time of the closure, lived just three blocks from Alta Vista Hospital. Now she had to make the 130-mile roundtrip drive to Santa Fe to access prenatal care. Coming home from her first ultrasound appointment, her SUV was struck by a powerful gust of wind, flipping the vehicle. Desiree and her unborn son, whom she had planned to name Ezra Augustine Castillo, were killed. Her husband Carlos survived the crash.

Over the next six years, Alta Vista made many unsuccessful attempts to fill its obstetrician positions. Finally, in 2022, it permanently shut its labor and delivery department, adding San Miguel County to the more than one in three New Mexico counties that do not have hospital-based maternity care.

Decline in the Number of Primary Care Physicians in New Mexico 2017–2021



Source: New Mexico Health Care Workforce Committee. 2023 Annual Report. October 1, 2023.

What happened at Alta Vista was not an isolated incident. Over the past decade, New Mexico hospitals in Artesia, Clayton, Gallup, and Tucumcari also permanently closed their maternity wards, and Raton may soon join them. And the shortages go far beyond maternity care: nearly every New Mexican has a story about having to wait months or even leave the state to access urgently needed health care, from surgeries to cancer treatment.

The main reason behind the shrinking access to health care is a severe and growing shortage of health care providers.

Between 2017–2021, New Mexico lost 30% of its primary care providers — a total of 711 doctors — according to the 2023 annual report of New Mexico Health Care Workforce Committee.[1]

1] The Health Care Workforce Committee was created by state statute in 2011 and consists of key stakeholders in New Mexico's state agencies and health care organizations, with staffing support from the UNM Health Sciences Center.

Number of Additional Health Care Workers Needed to Bring New Mexico Up to National Benchmarks

HEALTH CARE PROFESSION	NATIONAL BENCHMARK FOR NM	SHORTFALL
Registered Nurses & Clinical Nurse Specialists	19,443	5,704
Emergency Medical Technicians	6,763	4,967
Physical Therapists	2,010	526
Pharmacists	1,925	482
Primary Care Physicians	1,798	334
Physician Assistants	952	281
Certified Nurse Practitioners	1,775	231
Psychiatrists	339	119
Occupational Therapists	783	114
Dentists	973	88
Ob-Gyns	235	59

The health care professions included in this chart are selected from the limited number of professions that are tracked by the New Mexico Health Care Workforce Committee, so this should not be considered a comprehensive list. National benchmarks represent the total number of providers that New Mexico would need in order for the state to reach the national average of each type of provider, on a per capita basis. Shortfalls are calculated as the number of additional providers needed to reach the benchmark in all New Mexico counties, assuming no redistribution of current providers. Source: New Mexico Health Care Workforce Committee. 2023 Annual Report. October 1, 2023.

During a similar time period, the number of general practitioners nationwide increased by 3.8% according to data collected by the Association of American Medical Colleges.

New Mexico's loss of health care professionals is not limited to primary care physicians. Between 2017 and 2021, the New Mexico Health Care Workforce Committee found that the number of obstetrician-gynecologists practicing in New Mexico fell by 22%, and the numbers of registered nurses, dentists, psychiatrists, EMTs, and pharmacists also declined sharply.

Looking ahead, New Mexico has the oldest physician workforce in the nation, with over 39% of doctors age 60 or over and expected to retire by 2030. As a result, New Mexico's physician shortage is projected to more than double between 2020–2030, when it is expected to be the second worst in the nation, according to a 2020 analysis by researchers from the Cleveland Clinic, University of California, and Hershel Williams VA Medical Center.

Already the U.S. Department of Health and Human Services has designated part or all of 32 of New Mexico's 33 counties as health professional shortage areas, falling below national benchmarks in terms of access to doctors, nurses, and other health care providers. (The only county without a shortage area is Los Alamos.)

However, that data only tells part of the story. Even bringing New Mexico up to the national averages for the number of health care providers would not meet the full need for care in our state, especially considering that New Mexicans are, on

average, older and in poorer health than the national population. By 2040, nearly one in four New Mexicans are expected to be 65 or older, up from 13% in 2010, dramatically increasing the need for care.

The National Center for Health Workforce Analysis runs sophisticated projections of health care supply and demand, calculating a state's need for health care and how close the supply of providers comes to meeting that need — currently, and over the coming decade.

Their calculations show that if current trends continue, by 2035, New Mexico will have a shortage of 1,380 physicians, falling 22% short of meeting the statewide need for care. Similarly, the state will be short 5,140 nurses, failing to fulfill 19% of the need for care; and 3,460 allied health care professionals (e.g., physical and occupational therapists, sonographers, radiographers, medical technologists), failing to meet a staggering 52% of the need for this health care.

So how do we begin to reverse this cycle?

In this report, we highlight some important steps that have already been taken by policymakers to improve conditions for training, recruiting, and retaining health care workers in New Mexico, and we recommend additional reforms that can build on those initial steps and make a meaningful impact on New Mexico's health care worker shortage.

While the current crisis is daunting, this is not the first time New Mexico has faced such a challenge — and successfully overcome it.

A (VERY) BRIEF HISTORY OF HEALTH CARE WORKERS IN NEW MEXICO

The history of the supply of health care workers in New Mexico can be divided into several distinct periods of tremendous growth or tremendous contraction, almost always in response to accidents of history, like WWII, or government intervention, like the establishment of the University of New Mexico Medical School.

Prior to the Territorial period in New Mexico, many generations of Native American healers provided effective healing interventions, such as using plants native to the Southwest to make medicines. These practices continue today, as "more than 60% of Navajo patients surveyed had seen a traditional healer and about 40% [use] them regularly," according to the Archives of Internal Medicine.

Hispanic New Mexicans also have a centuries-long history of traditional healing practices, with *Curanderos* and *Curanderas* using herbal remedies and other natural methods to promote health and well-being. These practices also continue to be used in combination with Western medicine to provide a holistic approach to health and healing.

Traditional healers play a crucial role in expanding the health care workforce by providing culturally relevant care, bridging gaps in health care access, and offering services that are trusted and respected within their communities.

During the Territorial period, New Mexico developed a reputation as a health oasis and became a magnet for thousands of people who moved to our high desert for its dry climate, which was thought to be particularly effective for treating

tuberculosis. (One patient who came here for treatment was Carrie Wooster, who traveled from Ohio to Albuquerque along with her mother and a suitor, Clyde Tingley, who later became governor and helped open a dozen hospitals in New Mexico, including Carrie Tingley Hospital in Albuquerque.)

This migration of tuberculosis patients to New Mexico in turn caused a migration of many doctors to the state. The first year for which there is data about the number of health care professionals in the territory of New Mexico was 1874, when there were all of 14 doctors. Just a dozen years later, in 1886, that number had grown more than sevenfold to 99 doctors practicing in New Mexico, according to *Polk's Medical and Surgical Directory of the United States*. This surge led to the development of sanitariums and later to the founding of the first hospitals in New Mexico, including Presbyterian, St. Joseph, and Lovelace. By statehood in 1912, there were 429 doctors practicing in New Mexico.

Early statehood was still a period of scarcity of medical professionals for the local population, with one doctor for every 816 New Mexicans. However, an infusion of federal money during the New Deal began to reduce the shortage. For example, the number of public health nurses dramatically increased by the late 1930s to improve infant, child, and maternal health. This period also brought a new emphasis to preventive care and reliance on non-physician medical practitioners, such as nurses and midwives.

In the 1920s and 1930s, "New Mexico's physician supply experienced sharp contraction… [as] there were simply fewer new physicians entering the marketplace, while an older generation was dying out," according to Jake Spidle, author of *Doctors of Medicine in New Mexico*. In fact, the number of doctors fell from 529 in 1921 to 419 in 1938, more than a 20% contraction, even while the state's population grew by more than a third.


Just by KEEPING WELL
You can help win this war!
"Boss, we're 248 men short today—all sick!"
SICKNESS ON THE HOME-FRONT could lose this war. Sickness on the home-front stops men from getting to their jobs—stops planes and tanks and ships from getting to our fliers and our soldiers and our sailors.
We are facing a "doctor shortage," too. Nearly one-third of our doctors and nurses are going to war by the end of 1942. The two-thirds who are staying to care for the home-front are already busy. It's up to us to do everything we can to save their time by keeping well.
FOLLOW THESE 5 RULES
Memorize these five keys to good health. Follow them carefully—for your own welfare and for victory.
1. Eat right
Milk, butter, eggs, fish, meat, cheese, beans and peas, fruit, green leafy vegetables and the yellow ones, whole-grain or enriched cereals and bread—these are the key foods. Eat plenty of them. And eat 3 meals a day!
2. Get your rest
Regularity counts most. You can't catch up on lost sleep or missed relaxation! Try to keep on a regular schedule every day. Take it easy for a little while after lunch and dinner. Go to bed on time,

Excerpt of a public service announcement that ran in the *Albuquerque Tribune*, August 17, 1942.

World War II made the medical professional shortage even more severe as large numbers of medical professionals were drafted into the armed services. A column by the U.S. Public Health Service on August 17, 1942 in the *Albuquerque Tribune*, told readers that "Just by KEEPING WELL, you can help win this war!... Nearly one-third of our doctors and nurses are going to war by the end of 1942."

By September of 1943, the federal government announced it would cease recruiting doctors from 15 states, including New Mexico, because "the influx of workers [in these states] has made shortage of medical care critical."

The acute shortage of medical professionals continued to plague the state in the aftermath of the war, especially as the state faced an increasing need for health care for new veterans. However, it also set the stage to build the UNM School of Medicine as a way to increase the supply of doctors. The earliest mention of this ambitious idea was a proposal floated by the President of the New Mexico State Medical Society, Dr. Leland Evans, and published in the *Carlsbad Current Argus* on May 4, 1951. Dr. Evans' main argument was that while "the national average is one doctor for every 850 persons… New Mexico's average is one to every 1,500 and a number of counties only have one to 2,000 persons."

The President of UNM, Tom Popejoy, joined the effort in 1957, and in 1961, with the support of Governor John Burroughs, Popejoy persuaded the legislature to approve the establishment of a medical school. The UNM School of Medical opened in the fall of 1964 against the backdrop of the enactment of Medicare and Medicaid.

The school quickly expanded and made a gigantic contribution toward reducing New Mexico's medical shortage. When the school opened, there were 820 doctors practicing in New Mexico, a ratio of one doctor for every 1,192 citizens. Two decades later, the number of doctors in New Mexico had more than tripled to 2,522, and the ratio of doctors to citizens had greatly improved to one doctor to every 565 citizens, despite a period of high population growth.

Increase in the Number of Doctors in New Mexico Cities 1969–1985

CITY	1969	1985
Alamogordo	15	32
Albuquerque	533	1,363
Carlsbad	28	50
Clovis	25	36
Española	6	25
Farmington	23	65
Gallup	12	61
Hobbs	17	46
Las Cruces	36	131
Las Vegas	22	26
Los Alamos	24	44
Roswell	35	69
Santa Fe	95	232
Silver City	17	33

Source: Spidle, Jake W. *Doctors of Medicine in New Mexico: A History of Health and Medical Practice 1886–1986*. UNM Press. 1986.

Remarkably, as the chart above demonstrates, from 1969, the year after the medical school graduated its first class, through 1985, these new doctors practiced not only throughout the Rio Grande Corridor, but also in the more rural areas of New Mexico, benefitting every corner of the state. As a result, during this period New Mexico was getting closer to a balance between the supply of doctors and the demand for their services.

It did not last long. In 1980, the Graduate Medical Education National Advisory Committee produced a report warning that "in 1990 there will be 70,000 more physicians than required to provide physician services." This led them to advise that

The landscape for doctors was getting more treacherous.

Illustration by Andrew Toos, Courtesy Cartoonstock CS121007

"the number of medical students be decreased, that the entry of foreign medical graduates be curtailed, and that the appropriate number of nonphysician health care providers to be trained be reassessed." Not long after that, the American Medical Association added its sizeable political clout to encourage a reduction in the national supply of doctors.

The "doctor surplus" hysteria reached its apex in the mid-1990s when President Clinton and Congress provided millions of dollars to incentivize medical institutions to reduce the number of new doctors they trained. Federal lawmakers also froze the number of federally-funded medical residency slots, the final essential step in a doctor's training, at the number that existed in 1996. (They would not increase that number until 2020.)

However, the doctor surplus never arrived. By 1988, two years before the predicted surplus of doctors, an article in the *Albuquerque Tribune* noted that medical school was losing its appeal: the number of medical school applicants for the 1987–88 year was 10% lower than the 1986–87 year, and more than 30% lower than a decade earlier.

By 2000, studies by the *Journal of the American Medical Association* and the American College of Cardiology were acknowledging a "major miscalculation" by those who had predicted a surplus, and were instead anticipating a serious shortage of medical providers as the baby boom generation aged. Indeed, the medical professional shortage has continued to worsen in the past two decades, and has been accelerated by two recent events. First, the implementation of the federal Affordable Care Act, which added 172,000 newly insured patients in New Mexico. This greatly improved access to health care, but unfortunately it was not coupled with any measures to boost the number of health care providers.

Second, the COVID-19 pandemic burned out medical providers and caused them to leave the profession at high rates, both in New Mexico and across the country. That phenomenon was particularly acute in New Mexico, and it exacerbated existing health disparities, with the heaviest impacts on low-income and Tribal communities.

One of the principal lessons from this history is that policymakers always have the ability to change the equation and significantly increase the number of health care professionals practicing in New Mexico, just as they did when the governor and legislature established the UNM medical school. (Policymakers can also make the shortage worse, as the federal government did in the 1990s when it capped the number of residencies and incentivized medical institutions to reduce the number of doctors they trained.)

In the following pages, we outline an extensive, nonpartisan strategy that the governor and legislators can adopt to bring the supply and demand for medical services into balance in New Mexico, as well as a way to fund these reforms over the long term without raising taxes or cutting spending.

TRIBAL HEALTH CARE SYSTEMS IN NEW MEXICO

While the medical provider shortage negatively affects all New Mexicans, the heaviest impacts fall on the most vulnerable New Mexicans. Tribal citizens, in particular, face significant barriers, such as geographic isolation, resource limitations, and persistent health disparities. Tribal citizens also must navigate multiple interconnected health care systems, further complicating their access to essential care.

Pursuant to treaties between the federal government and sovereign Tribal Nations, the federal government is responsible for providing health care for members of federally recognized tribes. This responsibility stretches back to 1787 and is included in Article I, Section 8 of the U.S. Constitution. It has evolved over time, and was formalized in 1955 with the creation of the Indian Health Services (IHS) within the U.S. Department of Health and Human Services. IHS manages a system of clinics and hospitals for members of federally recognized tribes, and runs programs like the Indian Health Service Community Health Representative Program.

Under the 1975 Indian Self-Determination and Indian Assistance Act (Public Law 93-638), Tribes may choose to take their share of funding from IHS and instead directly provide their own health care. Several in New Mexico have done so.

State governments, including the state of New Mexico, have a government-to-government relationship with Tribes. This relationship requires ongoing collaboration, communication, and consultation between state agencies and Tribes, acknowledging the federal government's primary responsibility to these communities. In that government-to-government capacity, states and Tribes have worked together to create several innovative programs with a goal of improving access to health care for Tribal citizens.

One such program here in New Mexico is the recently created Shiprock-University of New Mexico (SUNM) Family Medicine Residency. Residents spend their first year in training at UNM hospital and then their second and third years at the Northern Navajo Medical Center, an IHS hospital in Shiprock. This is the first ever residency at an IHS facility, as well as the first residency on the Navajo Nation. In the years to come, it has the potential to train more medical professionals to serve Navajo patients.

The SUNM residency is just one example of the sort of collaborations that state agencies and institutions can pursue with New Mexico's 23 federally recognized Tribal Nations in order to increase the number of health care workers serving tribal members. Tribal citizens should also benefit from the various initiatives proposed throughout this report, from student loan repayment to career and technical education programs. By consulting with Tribal governments pursuant to their State-Tribal Consultation, Collaboration and Communication Policies, state agencies can shape these programs in ways that will best serve the needs of Tribal citizens.

REFORM NEW MEXICO'S MEDICAL MALPRACTICE ACT

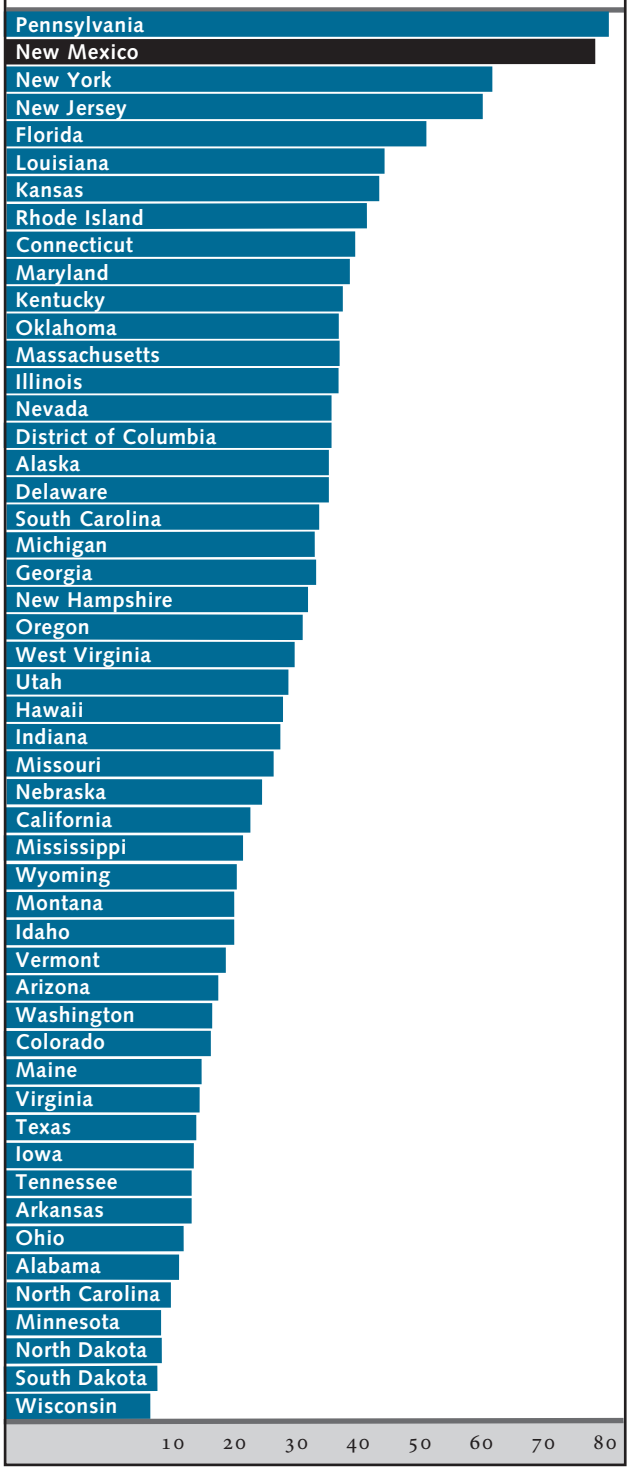
In the spring of 2024, a medical malpractice lawsuit over a botched hernia surgery resulted in a judgment of $68 million against Rehoboth McKinley Christian Hospital, the only hospital in Gallup, New Mexico other than Indian Health Service facilities. The hospital's insurance would cover a maximum of half that amount, leaving the hospital on the hook for the other $34 million — an impossible burden at a time when its net worth was estimated at negative $25 million. The hospital had recently received $5 million from the city of Gallup and county of McKinley in order to make payroll.

If the verdict stands, the hospital's attorney stated that it would have to either "seek bankruptcy protection, lay off employees, or cease operations." If the hospital closes, it would eliminate the main source of medical services for a 60-mile radius. The hospital currently serves 56,000 patients a year and employs about 340 people.

The massive malpractice verdict against Gallup's only hospital is not an isolated incident. New Mexico ranks second highest in the nation for the number of medical malpractice lawsuits per capita. There is one medical malpractice lawsuit for every 14,000 New Mexicans, more than twice the national average of one lawsuit for every 34,000 Americans, according to data compiled by the U.S. Department of Health and Human Services.

As a result, medical malpractice insurance premiums are about twice as high on average in New Mexico than they are in other states in our region, and those costs have been growing rapidly. From 2021–2022, New Mexico experienced the second largest increase in malpractice premium costs in the nation, according to a study by the American

States Ranked by Number of Medical Malpractice Lawsuits Per Million People



Source: 2023 Malpractice Report Data. National Practitioner Data Bank–Data Analysis Tool. U.S. Department of Health and Human Services.

2022 Medical Malpractice Insurance Loss Ratio by State

STATE	LOSS RATIO	STATE	LOSS RATIO
New Mexico	183.6%	New Jersey	73.1%
Delaware	141.4%	West Virginia	71.7%
Vermont	126.9%	Oklahoma	71.3%
Oregon	109.3%	Ohio	71.0%
Connecticut	105.6%	Arizona	70.1%
Alabama	105.6%	Massachusetts	69.5%
Iowa	100.1%	Kansas	67.0%
New Hampshire	99.3%	North Dakota	65.4%
Hawaii	99.2%	Minnesota	65.1%
Tennessee	93.1%	Illinois	61.9%
New York	88.6%	Idaho	61.4%
Pennsylvania	88.5%	Mississippi	58.3%
South Dakota	88.3%	Maryland	57.7%
Missouri	86.1%	Florida	56.9%
South Carolina	83.7%	Montana	55.8%
Georgia	82.2%	Colorado	54.7%
Washington	81.3%	Rhode Island	54.3%
Wisconsin	80.8%	Texas	54.0%
Utah	77.4%	Maine	53.0%
Indiana	75.9%	North Carolina	51.3%
Michigan	75.4%	Nevada	49.2%
Nebraska	75.0%	California	45.9%
Kentucky	74.3%	Louisiana	44.6%
Arkansas	73.8%	Wyoming	34.0%
U.S. Average	73.5%	D.C.	33.8%
Virginia	73.1%	Alaska	10.5%

Source: *2023 Medical Malpractice Financial Information: Annual Report*. Florida Office of Insurance Regulation. October 1, 2023.

Medical Association. For example, Roosevelt General Hospital in Portales saw its premiums rise from $330,000 in 2021 to $820,000 in 2023 — a 148% increase.

The average annual premium for a standard malpractice insurance policy for an independent provider in New Mexico is $43,020, according to data compiled by the New Mexico Superintendent of Insurance. Comparable policies average $22,030 in Arizona; $23,772 in Colorado; $28,487 in Texas; and $28,861 in Utah.

Even with these sky-high prices, many malpractice insurance companies end up losing money. The statewide loss ratio for medical malpractice insurers in New Mexico has exceeded 100% every year since 2018, meaning insurers are paying out more money in claims than they are receiving in premiums.

In 2022, the most recent year for which data is available, New Mexico's medical malpractice insurance loss ratio was the highest in the nation by a significant margin: 183.6%, compared to a national average of 73.5%. This means that for every $100 malpractice insurers received in premiums, they paid out $183.60 in claims. Understandably, only a handful insurers are willing to write policies for health care providers in New Mexico.

The high cost of malpractice insurance, and the high likelihood of being sued, discourage doctors and other health care workers from practicing in New Mexico.

The reason New Mexico has so many medical malpractice lawsuits is not that New Mexico doctors are committing malpractice at many times the rate of doctors in other states — rather, it is because the state has a system in place that incentivizes lawyers to file malpractice lawsuits here.

History of the New Mexico Medical Malpractice Act

To understand how we got here, we have to go back to the 1970s, when the entire nation was facing a medical malpractice insurance crisis. At that time, the number of medical malpractice lawsuits across the U.S. was rising rapidly, malpractice insurance premiums were soaring, and more and more insurers were ceasing coverage altogether because they were losing money on malpractice policies. In New Mexico, the underwriter for the New Mexico Medical Society's professional liability program, Travelers Insurance Companies, pulled out of the state, leaving many doctors without any options for insurance and jeopardizing their ability to continue practicing in the state.

In response, in 1976 New Mexico became one of 45 states to enact a Medical Malpractice Act. The goal of the law was to limit the liability of health care providers, keeping insurance available and affordable, while at the same time ensuring that injured patients were properly compensated and cared for.

Under New Mexico's Medical Malpractice Act, doctors and other health care providers are only responsible for a set amount of liability if they are sued for malpractice: as of 2022, those limits were set at $750,000 for independent physicians, up to $1 million for clinics, and up to $5 million for hospitals.[2] Health care providers must purchase insurance sufficient to cover claims up to these caps. Limiting the liability of health care providers reduces the potential financial exposure of their insurers, which brings down the cost of insurance.

Illustration by Edgar Argo, Courtesy Cartoonstock CS200109.

Then, to make sure that injured patients are fully compensated for any medical expenses caused by malpractice, the state created a Patient's Compensation Fund (PCF) to make up the difference between the liability cap and the actual medical costs incurred by the patient. New Mexico is one of seven states that has created this sort of fund.

The PCF is funded in large part by surcharges imposed on the health care providers who are participating in the Medical Malpractice Act. However, the legislature and governor have also periodically stepped in to appropriate supplemental funding for the PCF. Over the past three years, lawmakers have allocated nearly $100 million to the fund: $30 million in 2022, $32.5 million in 2023; and $35.9 million in 2024, in part to make up for a deficit caused by a couple of substantial malpractice verdicts.[3]

The Medical Malpractice Act functioned well for a time, but through the years, loopholes were

2] Under changes to the law enacted in 2021, the limits now include an annual inflation adjuster, so they increase each year. For example, as of 2024, the liability limit for independent physicians has increased to $883,404.

3] Not all health care providers participate in the Medical Malpractice Act. Those that do not participate simply purchase their own malpractice insurance policies and are not covered by the liability limits or the Patient Compensation Fund. For example, the Gallup hospital profiled at the beginning of this section does not participate in the Act.

opened up and flaws in the law became apparent, leading to the crisis that health care providers are currently experiencing.

In 2020, the New Mexico Superintendent of Insurance released a report recommending reforms to the Medical Malpractice Act. That report noted that having a high number of malpractice lawsuits not only increases the costs of insurance, it also "discourages providers from locating here, and drives others away" because providers are hesitant to practice in a state where they are likely to be sued over incidents that would not result in lawsuits elsewhere.[4]

The legislature and governor acknowledged the growing crisis of soaring medical malpractice premiums in the 2024 session when they appropriated $15.4 million to provide one-time rebates to health care providers to reduce the cost of their insurance premiums. Unfortunately, this was a temporary, one-year fix that did not address the underlying cause of the crisis.

We recommend six reforms that would prioritize the needs of patients while making New Mexico a better place for health care professionals to practice.

1) Cap Attorney's Fees

While the purpose of malpractice lawsuits is to compensate patients for their injuries, in reality a large portion of the money won in a lawsuit goes to the lawyer bringing the case, not to the injured patient.

In most malpractice cases, the lawyer bringing the lawsuit is paid on contingency. This means that the patient does not pay the attorney any money up front; instead, the lawyer receives a percentage of any money awarded if the case is successful—often 30–40% of the verdict. This means that as much as 40% of the dollars paid out in medical malpractice verdicts do not reach the patients; they go to the lawyers, many of whom work for law firms that are based outside New Mexico.

This can be a problem for patients with serious, long-term medical needs. Those patients generally receive large malpractice verdicts, which are based in part on the expected cost of caring for their injuries for the rest of their lives. Yet every dollar that goes to the lawyer is a dollar that is not available to pay for the patient's future medical care. While attorneys should be able to make a reasonable living representing the interests of injured patients, they should not receive multi-million dollar windfalls at the expense of gravely injured patients.

In order to better balance the interests of patients and the lawyers representing them, 20 states have enacted laws limiting attorney's fees in medical malpractice cases. The most common model, in effect in 11 states, is a sliding scale system of allowable fees. For example, Delaware limits attorney's fees to 35% of the first $100,000, 25% of the next $100,000, and 10% of any amount over $200,000.

4] It is important to note that not all doctors are directly impacted by New Mexico's medical malpractice insurance crisis. Health care professionals who work for state or federal institutions are subject to different, lower liability caps set by other laws, such as the Federal Tort Claims Act, which governs claims against Indian Health Service Facilities and Federally Qualified Health Centers. In addition, doctors and other professionals who are employed by hospitals do not directly bear the cost of malpractice insurance, as the hospital is responsible for purchasing it; however, the dollars that those hospitals are paying for exorbitant malpractice insurance premiums are not available for hiring additional health care providers or making salaries more competitive.

States that Cap Attorney's Fees in Medical Malpractice Cases

STATE	CAP ON ATTORNEY'S FEES
California	25% if settled prior to trial; otherwise 33%
Connecticut	33.3% of first $300,000; 25% of next $300,000; 20% of next $300,000; 15% of next $300,000; 10% of amounts over $1.2 million
Delaware	35% of first $100,000; 25% of next $100,000; 10% of higher amounts
Florida	30% of first $250,000; 10% of higher amounts
Hawaii	Court determines allowable fee
Idaho	Court determines allowable fee
Illinois	33.3%
Indiana	15% of any recovery from the Patient's Compensation Fund
Maine	33.3% of first $100,000; 25% of next $100,000; 20% of higher amounts
Massachusetts	40% of first $150,000; 33.3% of next $150,000; 30% of next $200,000; 25% of higher amounts
Michigan	33.3%
Nevada	40% of first $50,000; 33.3% of next $50,000; 25% of next $500,000; 15% of higher amounts
New Hampshire	50% of first $1,000; 40% of next $2,000; 33.3% of next $97,000; 20% of higher amounts
New Jersey	33.3% of first $500,000; 30% of next $500,000; 25% of next $500,000; 20% of next $500,000; court determines for higher amounts
New York	30% of first $250,000; 25% of next $250,000; 20% of next $500,000; 10% of higher amounts
Oklahoma	50%
Oregon	20% of punitive damages
Tennessee	33.3%
Utah	33.3%
Wisconsin	33.3% of first $1 million; 20% of higher amounts

Source: American Medical Association. *State Laws Chart I: Liability Reforms*. 2024.

Similarly, Nevada limits attorney's fees to 40% of the first $50,000; 33.3% of the next $50,000; 25% of the next $500,000; and 15% of any amount over $600,000. Florida caps attorney's fees for medical malpractice cases at 30% of the first $250,000 won in a lawsuit and 10% of any amount over $250,000.

Other states set a single cap (e.g., Illinois and Tennessee limit attorney's fees to one-third of the judgment) or allow the court to determine the attorney's fees applicable in each case. Indiana, which has a Patient's Compensation Fund similar to New Mexico's, caps attorney's fees on any money paid out of the fund at 15%.

We recommend that New Mexico join these 20 states and enact a cap on attorney's fees in medical malpractice lawsuits, as well as a cap on the amount of attorney's fees that may be paid out of the Patient's Compensation Fund.

2) End Lump-Sum Payouts

For many years, New Mexico's Medical Malpractice Act included a provision stating that: "payment for [future] medical care and related benefits shall be made as expenses are incurred." This meant that as a patient underwent treatment for any injuries caused by the malpractice, often for months or years into the future, those costs would be covered (initially by the doctor's insurance, up to the liability cap, and then by the Patient's Compensation Fund).

That all changed during the 2021 legislative session. As part of a large and complex revision of the Medical Malpractice Act, that phrase was quietly deleted. Suddenly, lawyers could seek a single, lump-sum payout based on an estimate of their client's lifetime medical costs.

The problem with this is that the lump-sum payout is meant to cover the patient's medical costs for the rest of their life, but up to 40% comes off the top immediately for their lawyer, making it impossible for the patient to receive enough money to adequately cover their costs. The patient may very well run out of money for their medical needs — unlike the prior practice in which patients kept receiving payments from the Patient's Compensation Fund to cover their medical costs.

Most New Mexicans would likely be surprised to learn that millions of public dollars from the "Patient's Compensation Fund" are not being used to compensate patients, but rather are going into large payouts to lawyers. As of March 2023, the fund was facing a projected deficit of $69 million by 2027, according to the Legislative Finance Committee.

We recommend that New Mexico end the practice of lump-sum payouts and restore the provision of the Medical Malpractice Act specifying that malpractice payouts are made as expenses are incurred. In tandem with the cap on attorney's fees, doing so would ensure that funds from the lawsuit will actually cover the costs incurred by the patient, as intended.

3) Stop Venue Shopping

A quarter-century ago, Pennsylvania was facing a medical malpractice crisis much like the one New Mexico is experiencing today. One of the major drivers of the problem was that lawyers could file medical malpractice lawsuits anywhere in the state, and they tended to choose locations where juries had track records of being more sympathetic to plaintiffs and awarding big verdicts. For example, lawyers won 36% of their malpractice cases in Philadelphia, compared to 12% and 9% in nearby Montgomery and Lancaster counties.

So even if a patient was injured by malpractice in a small rural community, the lawyer would often choose to bring the lawsuit in Philadelphia or Pittsburgh — where the jury had much less stake in whether the health care provider was able to stay in business.

In 2002, Pennsylvania lawmakers responded by enacting a law that required medical malpractice lawsuits be brought in the county where the alleged malpractice occurred. The law worked: the number of malpractice lawsuits filed each year fell from about 2,700 to 1,500, and insurance was once again available and affordable for health care professionals. [5]

Arkansas followed suit in 2003, and saw a similar reduction in the number of lawsuits filed. The number of insurance companies willing to write malpractice policies in Arkansas grew from two to nine following the enactment of the law limiting venue shopping.

Pennsylvania and Arkansas are not outliers: 30 states restrict venue-shopping in medical malpractice cases by requiring that they be filed either where the incident occurred or where the defendant is located.

5] Interestingly, the impact of the reform was underscored after the Pennsylvania Supreme Court eliminated it during a 2022 revision of the state's Code of Civil Procedure. In 2023, the number of medical malpractice filings surged in Pennsylvania and insurance rates increased significantly.

States with Venue Shopping Restrictions

Alabama	Mississippi
Alaska	Missouri
Arizona	Montana
Arkansas	Nebraska
California	Nevada
Delaware	North Dakota
Florida	Ohio
Georgia	Oklahoma
Hawaii	South Carolina
Idaho	South Dakota
Illinois	Tennessee
Iowa	Texas
Kentucky	Washington
Louisiana	West Virginia
Minnesota	Wyoming

Source: International Association of Defense Counsel. *50 State Medical Defense and Health Law Quick Guide*. 2016.

Here in New Mexico, the most serious medical malpractice cases—those involving wrongful death or incapacitation—can be filed anywhere the lawyer can arrange to have a personal representative represent the harmed patient. By moving those cases to parts of the state where juries tend to favor plaintiffs, trial lawyers have repeatedly racked up record-breaking verdicts.

For example, the lawsuit against the Gallup hospital that resulted in a $68 million dollar verdict was filed not in McKinley County, where the hospital is located, but 200 miles away in the First Judicial District in Santa Fe, where juries are often generous to plaintiffs.

We recommend that the New Mexico legislature and governor join the majority of states and require that medical malpractice lawsuits be brought in the county where the incident occurred, where the medical provider is located, or the county where the patient resided at the time of the alleged malpractice.

This reform is consistent with a recommendation made by the Office of the Superintendent of Insurance, which noted in its 2020 report that: "A venue located near where alleged malpractice occurred is more convenient for witnesses and providers, and ensures that providers are judged in accordance with the standards of the community in which they practice. It is more equitable for venue to have a closer nexus to the location of the malpractice."

4) Raise the Legal Standard for Punitive Damages and Cap Them

Under the 2021 amendments to the Medical Malpractice Act, New Mexico has the highest caps of any of the 29 states that cap malpractice liability. Yet even those high caps have often been rendered meaningless by loopholes in the law.

One such loophole is the issue of punitive damages. Punitive damages fall outside the limits of the liability cap, meaning they can be as high as a lawyer can convince a jury to award, and they are not paid out of the Patient's Compensation Fund, meaning that they fall solely upon the doctor or their employer.

Punitive damages are meant to be an extraordinary remedy, awarded in rare instances where it is necessary to punish gross negligence or intentional harm. Yet it has become routine for attorneys in New Mexico to seek punitive damages in medical malpractice cases, not only because they can increase the potential verdict, but also because they can be a powerful bargaining tool to convince medical professionals to accept a settlement rather than proceed to a trial.

States with Higher Standards of Proof for Punitive Damages than New Mexico

Alabama	Mississippi
Alaska	Missouri
Arizona	Montana
Arkansas	Nevada
California	New Jersey
Colorado	North Carolina
D.C.	North Dakota
Florida	Ohio
Georgia	Oklahoma
Hawaii	Oregon
Idaho	South Carolina
Indiana	South Dakota
Kansas	Tennessee
Kentucky	Texas
Maine	Utah
Maryland	West Virginia
Minnesota	Wisconsin

Source: Chu, Vivian. *Medical Malpractice Liability Reform: Legal* Issues and 50-State Surveys of Caps on Noneconomic and Punitive Damages and of Punitive Damages and of Punitive Damages Burden of Proof Standards. Congressional Research Service. March 1, 2011, updated by Think New Mexico.

Part of the reason why punitive damages can be used in this way is that New Mexico is one of just 13 states that requires lawyers to meet only the lowest burden of proof in order to win awards of punitive damages. In legal terms, the standard is known as "preponderance of the evidence," meaning that the jury only needs to find that it is more likely than not that punitive damages are warranted. So if a jury is only 50.1% confident that a doctor or hospital acted recklessly enough to justify punitive damages, they can award those damages—which can total tens of millions of dollars.

By contrast, 32 states and the District of Columbia set the bar significantly higher. Thirty-one states and DC require "clear and convincing" evidence, meaning that the jury must be firmly convinced that punitive damages are warranted; it must be substantially more likely than not, rather than just slightly. Colorado goes even further, requiring the highest burden of proof, "beyond a reasonable doubt," treating a finding of punitive damages as seriously as criminal charges. All five of New Mexico's neighboring states have higher standards of proof for punitive damages than New Mexico.

We recommend that New Mexico lawmakers raise the bar for awarding punitive damages from "preponderance of the evidence" to "clear and convincing" evidence, just as Idaho did in 2003 and West Virginia did in 2015.

Along with raising the burden of proof, we recommend that New Mexico join the 22 states that cap the amount of punitive damages that can be awarded in a lawsuit. These states limit punitive damage awards to either a dollar amount (e.g., New Jersey caps punitive damages at $350,000); a multiple of the other damages (e.g., Colorado caps punitive damages at no more than three times the amount of non-punitive damages); or a proportion of the defendant's assets or income (e.g., Kansas caps punitive damages at the lesser of $5 million or the defendant's gross annual income).

Five states—Illinois, Louisiana, Nebraska, New Hampshire, and Washington—ban punitive damages altogether in medical malpractice lawsuits.

States that Cap or Ban Punitive Damages

Alabama	Nebraska
Alaska	Nevada
Arkansas	New Hampshire
Colorado	New Jersey
Florida	North Carolina
Georgia	North Dakota
Idaho	Ohio
Illinois	Oklahoma
Indiana	Pennsylvania
Kansas	Texas
Louisiana	Virginia
Maine	Washington
Mississippi	Wisconsin
Montana	

Source: Chu, Vivian. *Medical Malpractice Liability Reform: Legal Issues and 50-State Surveys of Caps on Noneconomic and Punitive Damages and of Punitive Damages and of Punitive Damages Burden of Proof Standards*. Congressional Research Service. March 1, 2011, updated by Think New Mexico.

5) Prohibit Lawyers from Filing Multiple Lawsuits Over a Single Malpractice Incident

Another loophole in New Mexico's Medical Malpractice Act is that it fails to specify that all actions that contribute to an incident that harms a patient must be included in a single medical malpractice claim, rather than giving rise to multiple lawsuits. For example, a patient may be harmed because a doctor took one action, a nurse took another action, and so on, all of which contributed to the malpractice. Under current law, a lawyer can file a separate lawsuit for each separate action that contributed to the patient's injury, no matter how small.

Filing multiple lawsuits over a single injury is a strategy that lawyers can use to get around the caps on damages. For example, if a single lawsuit against a hospital can only result in a $5 million payout, three lawsuits over the same incident can triple that potential payout to $15 million.

In its 2020 report, the Superintendent of Insurance recommended that "malpractice claim" should be "defined in such a way that a single, individual injury event [is] treated as a single malpractice claim or occurrence, regardless of the number of contributing providers or acts." We concur in this recommendation.

6) Require that Damages Awarded for Future Medical Costs Reflect the Actual Cost of Care

A final loophole that should be closed in New Mexico's Medical Malpractice Act is that the payments for a patient's future medical expenses should reflect the actual costs paid for care.

As Think New Mexico explained in our 2014 policy report on the need for health care price transparency, hospitals and other large health care providers generally have what is known as a "chargemaster," essentially a list price for medical procedures. Similar to the price on a vehicle's window at a car dealership, that chargemaster price is just a starting point for negotiations. Each insurance company then bargains with the health care provider and agrees on a lower price than what is listed in the chargemaster, and those lower costs are what is actually paid for the care. Private insurers pay an average of 58% of the chargemaster price according to a 2023 study in the journal *Health Affairs*.

However, under New Mexico's current Medical Malpractice Act, attorneys seek payments for future medical costs based on the chargemaster prices for treatment, even though those are much

higher than the actual prices that the patient will pay. This inflates the judgement and thus increases the payout to the lawyer. (Similar to punitive damages, the cost of future medical care is also not subject to the liability caps.)

A fairer and more reasonable approach would be for the judgement to reflect the actual prices paid for care, not the inflated charges. We recommend that the legislature revise the law to limit malpractice awards for medical needs to the amounts actually paid.

The main beneficiaries of the variety of loopholes in New Mexico's current Medical Malpractice Act are lawyers, including some who work for law firms based outside New Mexico. The reforms proposed here would prioritize the needs of patients while making New Mexico a better place for health care providers to practice. This would ensure that when a patient is harmed by medical malpractice, they are fairly compensated and cared for in a way that does not undermine the health care system by driving health care providers out of the state or out of business.

Medical Malpractice Reform

Past Progress

- **Enactment of liability caps, though higher than in many other states**
- **Creation of the Patient's Compensation Fund and significant recent investment in it**

Further Recommendations

- **Cap attorney's fees from medical malpractice awards**
- **End lump-sum payouts from the Patient's Compensation Fund**
- **Stop venue shopping**
- **Raise the legal standard for punitive damages and cap them**
- **Allow only a single lawsuit for a single occurrence of malpractice**
- **Tie awards for medical costs to the actual costs incurred by the patient, not the inflated chargemaster price**

JOIN ALL TEN MAJOR INTERSTATE HEALTH CARE WORKER COMPACTS

Albuquerque parents Naomi Natale and Michael Casaus received heart-wrenching news in October of 2021 when doctors diagnosed their two-year-old son Sebastian with Stage 4 Myoepithelial Carcinoma, or MEC, a very rare and aggressive form of cancer.

Sebastian was admitted to the University of New Mexico Hospital, but because the disease is so rare, none of the doctors at the hospital had any experience treating patients with MEC. Naomi and Michael recalled, "We were being asked to make what felt like impossible medical decisions: What chemo drugs should be used? Should we amputate his hand? Should we try an experimental drug with potential long-term side effects?"

As most people would do under these circumstances, Naomi and Michael sought out second opinions from doctors who had experience treating this form of cancer at other cancer centers and hospitals across the country.

Naomi and Michael explained what happened next: "Many out-of-state physicians were willing to give us second opinions if we traveled to their facility. Because our son was on chemo and was severely immunocompromised, our oncologist recommended we avoid crowds and airports, so travel wasn't an option. [The out-of-state physicians] were willing to speak with us via video conference, but when they learned we were in New Mexico, they told us they would not be able to do so."

That is because the out-of-state physicians with the expertise to provide Sebastian and his parents with a second opinion would, in effect, be guilty of practicing medicine without a license—a fourth degree felony. Every state issues its own medical licenses, and a doctor or other health care professional must be licensed in New Mexico in order to treat patients here.

The best way to overcome this hurdle would be for New Mexico to join the Interstate Medical Licensure Compact (IMLC), an agreement among states that makes it simpler for doctors to practice in other participating states.

Similar to the way a person can hold a driver's license from one state and legally drive in another, states that participate in the IMLC agree to recognize medical licenses issued by other states. Importantly, state medical boards maintain final control over the licensure process and retain the right to refuse recognition of a license issued by another state. They also have access to a centralized database of disciplinary action records and the authority to require doctors to submit to FBI fingerprint-based criminal background checks. Doctors practicing in a state are subject to all of that state's rules, including the laws governing medical malpractice and insurance requirements.

Forty states, the District of Columbia, and the territory of Guam are parties to the IMLC, including all five states that border New Mexico. Unfortunately for Sebastian and his family, New Mexico is not one of the states in the compact. As a result, doctors licensed in other states cannot even provide services via tele-health in New Mexico without first going through the state's onerous and time-consuming licensure process.

This restriction particularly limits New Mexicans' access to medical specialists, since very few are based in New Mexico. (Michael and Naomi ended up driving to El Paso, Texas to consult via Zoom with an oncologist in Pennsylvania who was also licensed in Texas.)

Major Interstate Health Care Compacts

INTERSTATE COMPACT NAME	YEAR ESTABLISHED	NUMBER OF STATES IN THE COMPACT	IS NEW MEXICO IN THE COMPACT?
Enhanced Nursing Licensure formerly Nurse Licensure	**1999 (2017)**	**40**	**Yes**
Interstate Medical Licensure	**2015**	**41**	**No**
Physical Therapy	**2015**	**38**	**No**
Psychology Interjurisdictional	**2015**	**44**	**No**
Audiologist and Speech Language	**2016**	**33**	**No**
Recognition of EMS Personnel Licensure	**2017**	**31**	**No**
Occupational Therapy	**2019**	**31**	**No**
Counseling Interstate Licensure	**2020**	**37**	**No**
Physician Assistant Licensure	**2022**	**13**	**No**
Dentist and Dental Hygienist	**2023**	**10**	**No**

Source: National Center for Interstate Compacts; compiled by Think New Mexico.

The IMLC is just one of ten major interstate health care compacts, eight of which have been adopted by at least 31 states, as the above chart illustrates. The different compacts apply to different types of health care professionals, from EMTs to physical therapists.

New Mexico has adopted only one of the ten, the Nurse Licensure Compact. Under this compact, registered and practical nurses are granted a multistate privilege to practice in other compact states. As a result, nurses licensed by any of the other 39 compact states do not need to apply for a license to practice in New Mexico unless they make our state their primary state of residency.[6] Nurses practicing under the compact are still subject to the nursing laws and discipline in the state in which they are practicing, and nurses are not permitted to practice across state lines if they are under discipline.

As many as 80% of the nurses at some New Mexico hospitals, especially in rural and border areas of the state, would not be practicing here if not for this compact.

New Mexico is one of only five states that have adopted fewer than two interstate health care compacts. By contrast, our closest neighbors have adopted five or more interstate compacts — Arizona: six; Colorado: ten; Oklahoma: eight; Texas: five; and Utah: nine — meaning many different types of health care workers can move easily among them.

Joining these compacts would require New Mexico's legislature to adopt the language of each

6] Each of the compacts operates slightly differently. For example, the IMLC gives the state medical board the final authority as to whether to issue a license to any physician.

compact into law, as the 40 participating states and the District of Columbia and the territory of Guam have already done with the Interstate Medical Licensure Compact.

In 2023, state Representatives Marian Matthews (D-Albuquerque), Liz Thomson (D-Albuquerque), and Gail Armstrong (R-Magdalena) attempted to do just that when they introduced House Bill 247, a bipartisan bill to adopt the IMLC into state law. They also brought bills to join the compacts for psychologists, physical therapists, occupational therapists, and audiologists. All five bills passed the House Health and Human Services Committee 7-0, but died when they did not receive a hearing from the House Judiciary Committee.

The main argument made against adopting the interstate compacts is that doing so would harm state sovereignty, because it would allow other states to determine who is qualified to practice medicine, and some of those health care professionals licensed by other states would be allowed to practice in New Mexico. However, that apparently was not an issue for the 48 state legislatures that have adopted at least one interstate health care compact, and who presumably believe the benefits of joining the compact outweigh any harm to state sovereignty.

Some may also argue that the compacts are not needed because in 2023, New Mexico enacted a separate law creating an expedited licensure process for physicians and certain other licensed professionals. That law requires the state medical board to issue a one-year temporary license to health care professionals from other states within 30 days. The licensing board then completes a more in-depth review within that year-long window to grant a permanent license. However, applying for an expedited licensure is still more burdensome than what would be required under the compacts, and as of July 2024, just 72 expedited licenses have been issued.

We recommend that New Mexico join the nine other major interstate health care compacts and any future interstate healthcare compacts that make it easier for medical professionals to practice in New Mexico. This would be a highly effective strategy to immediately reduce the health care worker shortage and increase the number of qualified health care professionals who can practice in our state, ensuring that patients like Sebastian receive the medical care that they need.

Interstate Compacts

Past Progress

- **New Mexico joined the Enhanced Nursing Licensure Compact**

Further Recommendations

- **Join the other nine interstate medical compacts**

CREATE A CENTRALIZED CREDENTIALING SYSTEM

In the summer of 2024, New Mexico lawmakers learned that a years-long effort to expand access to behavioral health care in the state was being stymied by a surprising obstacle: the state's lack of a centralized credentialing process for health care workers.

Credentialing is the process by which medical organizations verify that a health care professional has the required qualifications to do their job. It involves confirming a health care professional's education and licensing status, and checking that there are no criminal or other violations against them. Health care institutions and insurers require credentialing in order to protect the safety of their patients by making sure that the health care professionals they employ or pay are fully qualified.

The problem is that a health care professional must be individually credentialed by every hospital or clinic they work for, as well as every insurance company that plans to pay for their services, including Medicaid. Every single one of these institutions has its own separate process that health care professionals must go through to become credentialed, which is burdensome and time-consuming.

Credentialing therefore becomes a barrier that prevents health care workers from being able to easily change jobs within the state, or to continue to provide care to a patient who moves from one type of insurance to another.

In the case of New Mexico's behavioral health workforce, one company, Western Sky Community

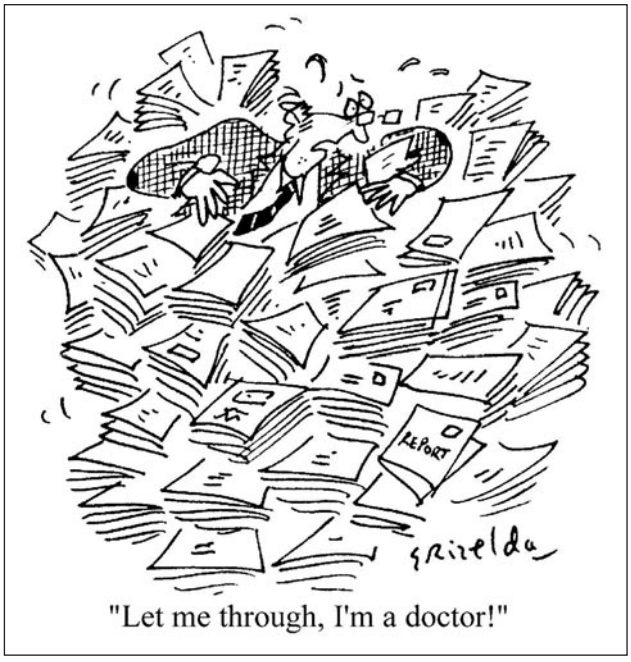


Illustration by Grizelda, Courtesy Cartoonstock CS229191.

Care, had successfully credentialed a growing network of counselors, psychologists, and therapists. However, when Western Sky Community Care's state Medicaid contract was not renewed in 2023, patients insured by Medicaid could no longer access that network of behavioral health care professionals—and many of them had not been credentialed by any other insurers. As a result, thousands of patients were cut off from accessing their counselors and therapists unless and until those professionals made it through the credentialing process with other providers and insurers.

The problem was summed up well in a report from the New Mexico Health Policy Commission entitled, *Standardize Licensing and Credentialing of Health Care Providers*:

> "For the State, as for hospitals and [insurance companies], the duplication and redundancy

is costly and inefficient. For the health care professional, the paperwork alone can be overwhelming, and the waiting time can be economically difficult. The burden created by these processes can be so great as to be a disincentive for health care providers to locate and practice in New Mexico, which defeats the original purpose of both licensing and credentialing: to provide better health care for all New Mexicans."

Sadly, although this description could have been written yesterday, it was actually published in October of 2002.

That year, the legislature unanimously passed House Joint Memorial 61, sponsored by Representative Terry Marquardt, an optometrist from Alamogordo and the second ranking Republican in House leadership at the time. The memorial called for a study of "the extensive duplication and redundancy within the licensing and credentialing processes currently in place in New Mexico … [which] creates a formidable barrier to the retention and recruitment of health care professionals in New Mexico."

Unfortunately, while the report that resulted from that study provided a cogent analysis of the problem, it yielded little in the way of substantive change.

In 2015, the legislature and Governor Martinez took a first concrete step toward improving the credentialing system when they unanimously enacted Senate Bill 220. That law directed the Superintendent of Insurance to approve no more than two standardized forms that medical institutions must use for credentialing health care professionals, and required that insurance companies act on an application for credentialing within 45 days of receiving it. As the fiscal analysis of the bill explained, that deadline "would allow doctors to accept new patients much more quickly without needing to wait months or a year" for the credentialing process to be complete. In 2023, the legislature tightened the deadline from 45 days to 30 after a complete application is submitted.

States with Centralized Credentialing

STATE	YEAR LAUNCHED
Arkansas	2002
Vermont	2007
Illinois	2022
Georgia	2016
Texas	2019
Maryland	2019
North Carolina	2019
Ohio	2022
Mississippi	2023
West Virginia	2023
Nevada	2024 *(expected)*

Source: Compiled by Think New Mexico.

Yet despite these positive steps, credentialing remains an unnecessary barrier to health care professionals practicing in New Mexico, as they still have to file their credentials repeatedly with different health care institutions and insurers. The overdue solution is a centralized credentialing system.

In such a system, a health care professional would submit their credentials once, to an agency such as the New Mexico Health Care Authority. That office would verify the accuracy of the data submitted, and once the health care worker is credentialed with them, all insurers and health care providers would be required to accept those credentials, rather than running their own credentialing processes.

Eleven states have already centralized the credentialing process for health care professionals, starting with Arkansas nearly three decades ago. In 1995, Arkansas lawmakers enacted legislation to implement a Centralized Credentials Verification Service. The law prohibits any duplicative credentialing processes: physicians submit their information to the CCVS, and health care institutions and insurers accept the CCVS credentialing. The CCVS continues to work well today, and its annual operating cost of around half a million dollars is more than covered by the fees charged on the groups that use the system.

States across the political spectrum have followed Arkansas' lead, with some requiring centralized credentialing for all health care professionals and institutions, and others limiting it to Medicaid providers and insurers. Some of the most recent states to enact centralized credentialing are Mississippi and West Virginia, whose centralized credentialing systems launched in July 2023; and Nevada, which is on track to implement centralized credentialing for all of its Medicaid programs by the end of 2024.

As New Mexico seeks to solve its health care professional shortage, the last thing our state should be doing is putting unnecessary obstacles in the way of health care workers seeking to practice in the state. We recommend that, after two decades of studying the problem of New Mexico's burdensome and duplicative credentialing process, state lawmakers adopt a single, centralized credentialing system.

Centralized Credentialing

Past Progress

- **Standardized credentialing forms**

Further Recommendations

- **Establish a centralized credentialing system where professionals only have to submit their credentials once**

EXPAND THE HEALTH PROFESSIONAL STUDENT LOAN REPAYMENT PROGRAM

For the last three decades, Jerry Harrison has run New Mexico Health Resources, a nonprofit whose mission is to recruit health care professionals to New Mexico. When the legislature asked him at a July 2024 presentation what he was hearing from potential candidates, he said that one of the top two questions he receives is: "can I receive student loan repayment for practicing in New Mexico?"

The answer is probably—but not as much as they can receive in many other states.

The question is top-of-mind for many doctors because they carry an average of $250,995 in student loans, according to the Education Data Initiative. The average dental school debt is even higher, at $293,900, while physician assistants carry an average of $112,500 and nurses carry an average of just over $47,000.

Many states have responded to these heavy debt burdens by creating student loan repayment programs to incentivize medical professionals to come practice in their state. (There are also multiple federal loan repayment programs available for doctors and other health care professionals, including through the Indian Health Service.)

New Mexico created its Health Professional Loan Repayment Program (HPLRP) in 1995 with the goal of increasing the number of health professionals practicing in underserved areas of the state. HPLRP is now available to more than 25 different health care occupations, including doctors, nurses, dentists, mental health professionals, and allied health fields (e.g., audiologists, EMTs, nutritionists, occupational and physical therapists, medical technicians, pharmacists, etc.). These health

States with Higher Student Loan Repayment for Physicians than New Mexico

STATE	MAX LOAN REPAYMENT
California	$300,000 over five years
Massachusetts	$300,000 over five years
Michigan	$300,000 over ten years
Vermont	$300,000 over six years
Georgia	$250,000 over four years
Arizona	$220,000 over six years
Delaware	$200,000 over four years
Maryland	$200,000 over four years
Nebraska	$200,000 over five years
New Jersey	$200,000 over four years
Oklahoma	$200,000 over four years
Tennessee	$200,000 over five years
Louisiana	$180,000 over seven years
Texas	$180,000 over four years
Alabama	$150,000 over three years
Florida	$150,000 over four years
Montana	$150,000 over five years
North Dakota	$150,000 over five years
Oregon	$150,000 over three years
Virginia	$140,000 over four years
Minnesota	$132,000 over four years
Colorado	$120,000 over three years
Nevada	$120,000 over three years
New York	$120,000 over three years
New Hampshire	$115,000 over five years
Hawaii	$100,000 over two years
Idaho	$100,000 over four years
Kentucky	$100,000 over two years
North Carolina	$100,000 over four years
West Virginia	$100,000 over four years
Wisconsin	$100,000 over two years
Kansas	$95,000 over five years
Alaska	$94,000 over two years
Utah	$90,000 over three years
Ohio	$85,000 over four years
Pennsylvania	$80,000 over two years
New Mexico	$75,000 over three years

Source: Compiled by Think New Mexico.

care professionals are eligible to receive up to $25,000 per year toward their student loan debt in exchange for practicing full-time in a designated medical shortage area for at least three years, for a total of up to $75,000 in loan repayment.

Unfortunately, for many years HPLRP had a fatal flaw: until 2023, it was so underfunded that almost no one actually received the loan repayments. For example, in 2022, HPLRP only had enough funding to award loan repayments to 44 of the 649 health care professionals who applied to receive it—a rate of about 7%.

This made HPLRP less like a loan repayment program and more like a lottery that health care professionals were very unlikely to win. As a result, health care employers were not able to use HPLRP as a recruiting tool for prospective employees because there was such a low likelihood that they would actually receive any funding.

Recognizing the need to address this problem, the legislature and governor took action and significantly expanded HPLRP in 2023, increasing its funding from $1.7 million to $14.6 million. This additional funding meant that, in one year, the number of students receiving loan repayment grew from 44 to 724! At the same time, a bipartisan group of legislators led by Representatives Kristina Ortez (D-Taos), Gail Armstrong (R-Magdalena), Joshua Hernandez (R-Rio Rancho), Natalie Figueroa (D-Albuquerque), and Reena Szczepanski (D-Santa Fe) won passage of legislation to expand the service requirement from two years to three, meaning doctors were eligible to receive $75,000 (three years at $25,000 a year), rather than just $50,000 (two years at $25,000 a year). Their bill also expanded eligibility for the program to all types of doctors, as it had previously only been available to primary care physicians.

However, even with this impressive expansion, New Mexico remains at a disadvantage to other states. If a doctor qualifies for HPLRP and successfully completes the three-year practice requirement, by the end of their service the $75,000 they earn would cover less than a third of the average medical graduate's student loan debt.

By contrast a health care professional can receive $120,000 for three years of service in Colorado ($40,000 a year), $180,000 for four years of service in Texas ($45,000 a year), and $200,000 for four years of service in Oklahoma ($50,000 a year). A total of 36 states offer loan repayment programs in which doctors—and in many cases other health care professionals as well—can receive higher amounts of student loan repayment than they can in New Mexico.

Because we are in a national competition to attract medical talent, New Mexico should aim to make our incentive programs as competitive as possible with those available in other states. As a starting point, the 2023 New Mexico Health Care Workforce Committee report recommends that lawmakers double the funding for the loan repayment program to $30 million annually (an amount that Governor Lujan Grisham has also consistently included in her executive branch budget recommendation). This would ensure that every eligible health care professional who applies for HPLRP would receive the full loan repayment, making it closer to a guarantee than a lottery ticket.

Beyond funding the program at a level that will reach every eligible applicant, another reform that would increase the effectiveness of the HPLRP

would be to allow health care professionals to earn more loan repayment in exchange for providing additional years of service.

For example, in Michigan, eligible health care workers can earn up to $300,000 in student loan repayment over a ten-year period. The amount they can earn each year is capped at $40,000, and they are only required to serve a minimum of two years. However, if a health care professional chooses to stay for additional years, they can continue to earn loan repayment each year for up to a decade. This structure provides a strong incentive for health care professionals to not just come to Michigan, but to stay for a significant length of time.

We would recommend that New Mexico keep its minimum required service commitment at three years, as too long a required commitment can serve as a disincentive for health care workers to participate, but we also recommend adding optional fourth and fifth years to the program. Researchers who study the science of "place attachment" have found that it takes 3–5 years for most people to feel at home and form connections in a new place, and once they have forged that connection, they are more likely to stay for an extended period.

Most importantly, with these additional years we recommend that New Mexico increase the maximum amount of loan repayment that medical professionals can earn from $75,000 to $200,000.

There are a couple different ways to structure that increase. First, the state could raise the amount of the repayment every year, with participants earning up to $30,000 in the first year, $35,000, in the second year, $40,000 in the third year, $45,000 in the fourth year, and $50,000 in the fifth year. This is similar to the way that Montana structures its loan repayment program.

Alternatively, the state could simply raise the current $25,000 available each year to $35,000 a year in the first three years of service, and then increase the amounts to $45,000 and $50,000 respectively in the optional fourth and fifth years.

Increasing the total loan repayment available to $200,000 would make New Mexico's loan repayment program competitive nationally and regionally—higher than Colorado and Texas, equal to Oklahoma, and very close to the amount available in Arizona. (It would also be wise to add an inflation adjuster to the loan repayment levels so that their value is not eroded in future years.) We estimate that this expansion will cost $18.2 million a year, which can be paid for with the health care permanent fund described later in this report.

Allowing health care professionals to earn additional loan repayment in exchange for more years of service is truly win-win: health care professionals could pay down more of their student loan debt, and New Mexico could retain critically needed health care workers for longer time periods.

Student Loan Repayment

Past Progress

- **Creation of the HPLRP**
- **Expansion of HPLRP by $13 million**
- **Addition of more professions to HPLRP**

Further Recommendations

- **Fund the loan repayment program at a level that reaches all qualified applicants**
- **Increase the maximum local repayment from $75,000 to $200,000 by expanding the program to include optional fourth and fifth years of service**

MAKE NEW MEXICO'S TAX POLICY MORE FRIENDLY TO HEALTH CARE WORKERS

Permanently Repeal New Mexico's Gross Receipts Tax on Medical Services

One large factor in New Mexico's struggle to attract and retain doctors, nurses, and other medical professionals is that we pile on extra costs that health care workers in most other states do not have to pay. The most obvious of these is New Mexico's Gross Receipts Tax (GRT) on medical services.[7]

New Mexico and Hawaii are the only two states that impose a GRT on the medical services provided by doctors and other health professionals. (Michigan and Ohio have a limited medical services use tax on Medicaid managed care organizations.)

Unlike most businesses, who simply pass on the gross receipts tax to their customers, medical providers are not allowed to do that. The federal government makes it illegal for medical providers to pass along a GRT to patients covered by Medicare or Medicaid. Likewise, private health insurers do not reimburse for the GRT in their contracts with medical providers.

This means that health care professionals like doctors, dentists, and mental health care providers

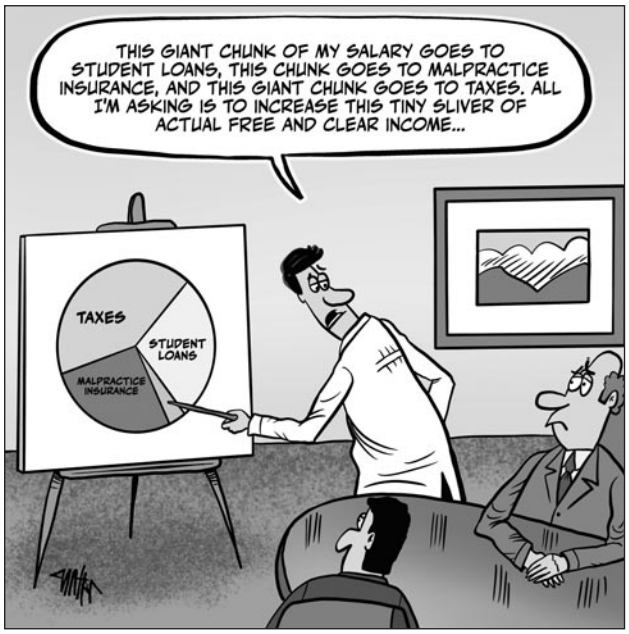


Illustration by Jon Carter, Courtesy Cartoonstock CS553106.

cannot pass this tax on to their patients and must instead pay the tax on co-pays and deductibles themselves.

Because each city and county can add their own local GRT on top of the state rate, the full GRT in New Mexico ranges from 5.25% in the unincorporated areas of Lea and Lincoln counties to 9.4375% in Taos Ski Valley. The statewide average GRT is 7.05%, according to the New Mexico Taxation and Revenue Department. If you are a medical professional in private practice, you not only need to absorb this substantial cost but also pay staff to handle the tax filings and associated paperwork.

So how did New Mexico come to be one of just two states with a GRT on medical services? The origins of the GRT on medical services can be traced back to the Great Depression. At that time, state and local governments in New Mexico and across the United States were mostly funded by property taxes, but property values plummeted during the Great Depression, and with them gov-

7] Most states have a sales tax, but New Mexico is in the minority of states that has a gross receipts tax. A gross receipts tax is imposed on the person who is selling a good or service, while a sales tax is imposed on the person who is buying a good or service. New Mexico's GRT means that doctors and other medical providers are taxed on the services they provide.

ernmental revenues. To make up for the lost tax revenue, many states began to impose a sales tax. Mississippi became the first state to levy a general sales tax, and New Mexico was not far behind. In 1935, New Mexico passed its sales tax, called the "Emergency School Tax." Medical services were included, and were taxed at a rate of 2%.

In 1962, revenues from the Emergency School Tax were no longer restricted to the public schools, going instead to the General Fund, which funds the state's budget. Shortly thereafter the tax was revised to the GRT that is still in place today. Over time, the state GRT tax rate has grown from 2.0% to 4.875%, and counties and cities have added on their own local GRTs on top of the state rate, within certain limits.

In 2004, the legislature and Governor Bill Richardson abolished the tax on food and, in the same legislation, exempted the tax on medical services for some providers. The goal, according to the legislation's Fiscal Impact Report, was to increase provider take-home pay and to enhance recruitment and retention of medical providers.

Over the past two decades, the legislature and governors have wisely continued to exempt more and more medical providers and services from the GRT. This culminated during the 2023 legislative session, when the legislature and Governor Michelle Lujan Grisham suspended the remaining portion of the GRT on medical services for five years. However, unless they take further action, that suspension will expire and the tax will return on July 1, 2028.

To make New Mexico more competitive in the fight to attract and retain doctors and other medical professionals, we recommend repealing the sunset clause and permanently exempting all medical services from the GRT. There would be no cost to the state's General Fund from doing so, as the most recent budget assumes the tax will not bring in any revenue because it has been suspended.

Increase and Expand the Rural Health Care Practitioner Tax Credit

On the other side of the ledger, one helpful section of the tax code in terms of giving New Mexico a competitive advantage in attracting and retaining medical providers is the Rural Health Care Practitioner Act (RHCPA). It was enacted in 2007 by the legislature and Governor Richardson. RHCPA reduces state income tax liability for higher-earning medical professionals practicing in rural areas, and eliminates that tax liability entirely for lower-paid health workers in rural areas.

RHCPA provides an annual $5,000 income tax credit to licensed doctors, dentists, clinical psychologists, podiatrists, and optometrists who practice in rural areas. It also provides a $3,000 credit to licensed dental hygienists, physician assistants, certified nurse midwives, certified nurse anesthetists, certified nurse practitioners, and clinical nurse specialists.

In 2024, Representatives Miguel Garcia (D-Albuquerque) and Jenifer Jones (R-Deming) led a suc-

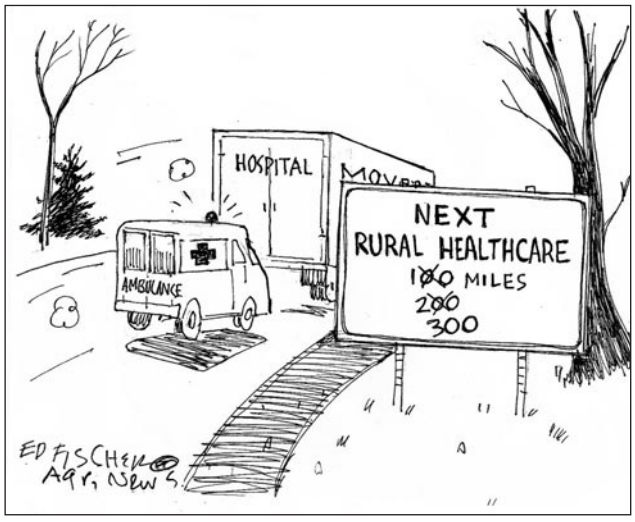


Illustration by Ed Fischer, Courtesy Cartoonstock CS347270.

cessful effort to significantly broaden RHCPA, making pharmacists, registered nurses, social workers, therapists and counselors, alcohol and drug abuse counselors, midwives, and physical therapists eligible for the $3,000 annual credit. During the 2023 tax year, 2,101 providers received the Rural Healthcare Tax Credit (RHTC).

While the RHTC has been widely praised in terms of attracting and retaining doctors in rural areas and improving access to care, it could be even more impactful if it were increased and expanded.

First, we recommend that the amounts in the RHTC be increased to take into account the fact that its value has been eroded by the inflation that has occurred since the law was enacted in 2007. For instance, $5,000 adjusted for inflation since 2007 would now be $7,760, and $3,000 adjusted for inflation since 2007 would now be $4,656. We recommend that lawmakers increase the RHTC to these levels and index it to inflation going forward, so that it does not continue to lose value.

Second, we recommend that the RHTC be expanded to include a number of additional health care professionals in areas where the shortages in rural New Mexico are dire. These include emergency medical technicians (EMTs), paramedics, occupational therapists, audiologists, speech and language pathologists, licensed practical and licensed vocational nurses.

For example, since 2016 New Mexico has lost about 19% of our EMTs, 1,134 people in total. The 2023 New Mexico Health Care Workforce Committee Report notes that "an additional 4,967 EMTs would be needed for all New Mexico counties to meet the national benchmark (32.1 per 10,000 population)."

Finally, we recommend requiring that recipients of the RHTC accept patients who are insured under Medicaid, as several other states with similar tax credits already do.

Currently, the Rural Healthcare Tax Credit costs the General Fund $18.8 million. With the increase and expansion outlined above, it would bring the total cost to $27.7 million, or an increase of $8.9 million.

In the final section of this report, we explain how this expense could be covered without raising taxes or cutting spending through the creation of a Permanent Health Care Trust Fund. (Alternatively, the cost could be covered by an increase in the state's alcohol excise tax, which has not been increased in more than three decades.)

Tax Reforms

Past Progress

- **Temporary suspension of the GRT on medical services**
- **Creation and initial expansion of the Rural Health Practitioner Tax Credit**

Further Recommendations

- **Permanent repeal of the GRT on medical services**
- **Further expansion of the RHTC and index it to inflation**

ENHANCE MEDICAID REIMBURSEMENT & REDUCE MEDICAID CLAIM DENIAL RATES

One reason why health care professionals generally earn less in New Mexico than they do in other states has to do with how most New Mexicans are insured.

A decade ago, Think New Mexico published a report on the need for health care pricing transparency.[8] In that report, we explained that when a patient walks into a health care facility for treatment, the amount of money that the clinic or hospital will be paid varies dramatically based on the patient's insurance status. Private insurers each negotiate their own individual rates with health care providers, while the federal government sets payment rates for Medicare (covering older patients), and state governments set rates for Medicaid (covering lower-income patients).

Medicare reimbursement rates are designed to cover the cost of providing care without any allowance for profit. The American Hospital Association (AHA) has long contended that Medicare rates actually fall a bit short of covering the full cost of treatment, and a 2017 study by Medicare concurred, finding that their reimbursements to hospitals totaled about 90% of the cost of care. (By contrast, private insurance pays an average of 144.8% of the cost of care according to the AHA.)

Medicaid rates are usually even lower than Medicare—nationally they averaged just 78% of Medicare reimbursement rates. That is the source of New Mexico's unique challenge.

New Mexico has a higher proportion of our population insured under Medicaid than any other state. Around 42% of New Mexicans—911,514 people

Percent of the Population Insured by Medicaid

STATE	MEDICAID %	STATE	MEDICAID %
New Mexico	41.7%	Maryland	27.0%
Louisiana	41.3%	Nevada	26.8%
New York	37.7%	Iowa	26.2%
West Virginia	36.3%	Maine	26.0%
Alaska	35.9%	Mississippi	25.6%
California	35.9%	Tennessee	24.5%
Kentucky	35.4%	Wisconsin	23.8%
Arkansas	33.3%	South Carolina	23.6%
Rhode Island	32.8%	New Jersey	23.4%
Oregon	32.3%	Minnesota	23.3%
Hawaii	31.8%	Missouri	22.7%
Oklahoma	31.4%	Virginia	22.6%
Arizona	30.5%	Alabama	22.6%
Michigan	30.1%	Idaho	22.4%
Illinois	30.0%	Georgia	22.0%
Vermont	29.6%	Florida	21.1%
Indiana	28.8%	North Carolina	21.1%
Delaware	28.6%	Nebraska	19.3%
Colorado	28.4%	Texas	18.5%
Ohio	28.3%	New Hampshire	17.5%
Montana	28.2%	Kansas	16.9%
Pennsylvania	28.2%	North Dakota	16.2%
Massachusetts	27.9%	South Dakota	15.5%
Connecticut	27.6%	Wyoming	13.9%
Washington	27.5%	Utah	13.8%

Source: U.S. Centers for Medicare & Medicaid Services. *Medicaid Enrollment by State 2024*.

8] That report led to the creation of a health care price transparency website, which will soon be online and linked to Think New Mexico's website.

as of August 2024—are insured by Medicaid.

By comparison, the percentage of people insured under Medicaid is 30.5% in Arizona, 28.4% in Colorado, 18.5% in Texas, and 13.8% in Utah. The national average is around 27%.

In addition to the 42% of New Mexicans covered by Medicaid, another 21% are covered by Medicare, and 8% are uninsured and may only be able to pay a fraction of the cost of their care.

The bottom line is that, for more than two out of every three patients that they treat, New Mexico's health care providers are breaking even or losing money. This puts health care providers in New Mexico at a severe financial disadvantage to those in other states, and makes it much more appealing to practice medicine elsewhere.[9]

However, this challenge is also an opportunity because New Mexico policymakers have direct control over the rates providers receive for patients insured by Medicaid, and they have already taken several steps to raise them.

Unlike Medicare, which is entirely controlled by the federal government, Medicaid operates as a federal-state partnership. The federal government provides the vast majority of the funding; for example, in the most recent fiscal year, the New Mexico state budget included $1.9 billion to cover Medicaid patients, which was matched by $7.3 billion in federal funding.[10] Meanwhile the state administers the program and determines the rates that health care providers are paid for treating Medicaid patients.

Those Medicaid payment rates are generally set as a percentage of Medicare rates. In 2022, the Legislative Finance Committee, the legislature's budget staff, published a report recommending that the state bring its Medicaid rates up to 100% of Medicare — and higher for specialties where the state was particularly short of providers.

The following year, the legislature and governor did so, appropriating $98 million to bring most Medicaid rates up to 100% of Medicare, and rates for primary care, behavioral health, and maternal and child health care up to 120% of Medicare. (Medicare sets rates for child and maternal health care because around 12% of the population it covers are non-elderly disabled people.)

In 2024, lawmakers built on this progress, adding another $28.14 million to raise the rates for primary care and maternal and child health services up

9] Many doctors and other health care professionals who are employed by a hospital or other health care provider receive fixed salaries, which are not directly determined by the percentage of Medicaid, Medicare, or privately insured patients they treat. However, some portion of health care professional compensation is often tied to the overall revenues of the organization that employs them, and those revenues are impacted by the patient mix. Moreover, the high proportion of patients on Medicaid and Medicare mean that hospitals and other health care employers in New Mexico are bringing in less money than their counterparts in other states, which in turn means they have less money available to hire additional health care workers or invest in salaries. This makes it challenging for New Mexico institutions to compete in the national labor market for health care professionals.

10] The federal Medicaid matching rate for each state is determined by a complex formula designed to provide more money to states with lower per capita incomes relative to the national average. The federal government generally provides about 74% of New Mexico's Medicaid budget, but that percentage has been higher in recent years due to pandemic-related appropriations.

Illustration by Jeffrey Koterba, Courtesy Cartoonstock EC434217.

to 150% of Medicare rates. They also earmarked $35.5 million to maintain other Medicaid rates at 100% of Medicare rates.

This is impressive progress toward ensuring that health care providers in New Mexico are compensated at levels comparable to those in other states. Yet, given the extremely high proportion of the state's population covered by Medicaid, it may not be enough. For example, in its 2023 annual report, the New Mexico Health Care Workforce Committee recommended that the state "create a five-year plan to reach 250% of Medicare rates by 2030." We encourage state policymakers to continue to build upon their progress in increasing reimbursement rates.

Target the Rate Increases to Provider Salaries

In addition to simply raising the Medicaid reimbursement rates, New Mexico lawmakers should also address an often overlooked piece of the puzzle: ensuring that higher reimbursement rates actually reach the health care professionals who are providing the care.

Most doctors and other health care workers in New Mexico are employed by a clinic, hospital, or other facility. Medicaid reimbursement rates are paid to that facility, and the facility can spend them on whatever it chooses, including equipment, staff salaries, or administrative costs. As a result, simply paying higher Medicaid rates does not guarantee that those additional dollars will trickle down to higher paychecks for health care workers.

To remedy this, we recommend that New Mexico lawmakers require that a minimum percentage of any additional increase in Medicaid reimbursement rates—such as 95%—must be used for non-administrative staff salaries whenever feasible.[11] Any health care facilities receiving Medicaid dollars would have to show that the additional funds being received are being used to pay health care workers. They would also have to demonstrate that this new funding is not supplanting current spending on staff salaries: in other words, providers would be required to hold steady their existing baseline of spending on staff salaries, and use the additional money from higher reimbursement rates to increase those salaries and hire more health care workers.

A similar strategy has been implemented by multiple states going back more than two decades, often with a focus on lifting the wages of the lowest-paid health care workers, such as nursing home aides. In 2022, a study by the National Governors Association found that 19 states were

11] The state does not have the power to establish such spending requirements with regard to federal facilities, such as those run by the Indian Health Service, or tribal health care facilities.

implementing programs in which they coupled targeted increases in their Medicaid rates with a requirement that a certain amount of that increase be used for health care worker wages. For example, in 2021 Indiana increased its Medicaid reimbursement rates for home-based health care by 14% and required that 95% of that increase must be used to increase the wages and benefits of home-based health care workers.

Bring Down High Medicaid Claim Denial Rates

There is one other factor that results in health care providers receiving less money for treating patients insured by Medicaid than for other patients: high claim denial rates.

Nationally, Medicaid programs deny provider claims for payment at much higher rates than other types of insurance. A 2023 study by researchers at the University of Chicago and Columbia University found that 24% of Medicaid claims are at least partially denied, compared with 6.7% of claims submitted to Medicare and 4.1% of claims submitted to private insurance.

As a result, the researchers calculated that physicians lose an estimated 18% of the money they should receive for treating Medicaid patients due to improper claim denials and the time they had to spend resolving them. By contrast, providers only lost 4.7% of the dollars they should have received for Medicare patients and 2.4% for patients covered by private insurance.

In July of 2023, the Office of the Inspector General for the U.S. Department of Health and Human Services issued a report addressing one aspect of this problem: Medicaid's high rates of prior authorization denials relative to other insurers. That study noted that several states had implemented reforms to bring down the rate of Medicaid claim denials.

Thirteen states conduct regular reviews of the appropriateness of prior authorization denials, and 14 states—spanning the political spectrum from California to Mississippi—require automatic external medical reviews of denials, something that is also required by the federal Medicare Advantage program. When submitted for external medical reviews, 46% of Medicaid denials were overturned in favor of the patient—and in favor of paying the health care provider. The Health and Human Services report urged states that have not yet implemented these reforms to do so.

States Requiring Automatic External Reviews of Medicaid Prior Authorization Denials

California	New York
Illinois	Pennsylvania
Indiana	Rhode Island
Kentucky	Utah
Michigan	Washington
Mississippi	Wisconsin
New Jersey	West Virginia

Source: Grimm, Christi A. *High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care.* U.S. Department of Health and Human Services–Office of the Inspector General. OEI-09-19-00350. July 2023.

Most states implementing these automatic reviews do so without creating any additional state bureaucracy. Instead, the state simply requires the insurance companies that contract with the state to provide Medicaid coverage to pay for external reviews of denials. This changes the incentive for the insurance company by making it more expensive to reject a claim, which should help reduce the rate of claim denials.

We urge New Mexico lawmakers to implement automatic external medical reviews of Medicaid claim denials, in order to ensure that health care providers treating Medicaid patients receive the full compensation that they are due.

Medicaid Reforms

Past Progress

- **Significant increases in Medicaid reimbursement rates**

Further Recommendations

- **Continue to increase Medicaid reimbursement rates**
- **Ensure that a significant percentage of any additional increase reaches health care professionals**
- **Reduce Medicaid claim denial rates by requiring automatic external reviews of Medicaid claim denials**

GROW MORE OF OUR OWN I: EXPAND THE PIPELINE WITH CAREER & TECHNICAL EDUCATION

Meet Dr. Heather Kovich, a family medicine doctor in Shiprock, New Mexico for 15 years and Chief of Staff at Northern Navajo Medical Center (NNMC), an Indian Health Service hospital. She is also the author of a recent essay in the *New England Journal of Medicine* on the challenges of recruiting and retaining doctors in rural New Mexico, titled, "And how long will you be staying, doctor?" The title refers to the most frequently asked question she and her colleagues receive from their patients, who directly experience the difficulty of retaining and recruiting doctors.

This is a challenge not just for New Mexico, but for many rural communities across the country. As Dr. Kovich observes, "twenty percent of the US population is rural, but only 11% of physicians practice in rural settings, even though residents of rural areas are older and have worse health indicators than their urban counterparts… physician supply is driven by where physicians want to live, not by the health needs of the community."

Indeed, like many medical centers and hospitals in rural New Mexico, NNMC is chronically understaffed. Specialists are particularly difficult to recruit. For example, NNMC had a vacancy for an Ear, Nose, and Throat (ENT) specialist for about a decade before deciding to permanently refer those cases to other facilities because they were unable to recruit an ENT doctor to Shiprock.

Overall, NNMC generally runs 20% short of full staffing of physicians. And it is not just doctors

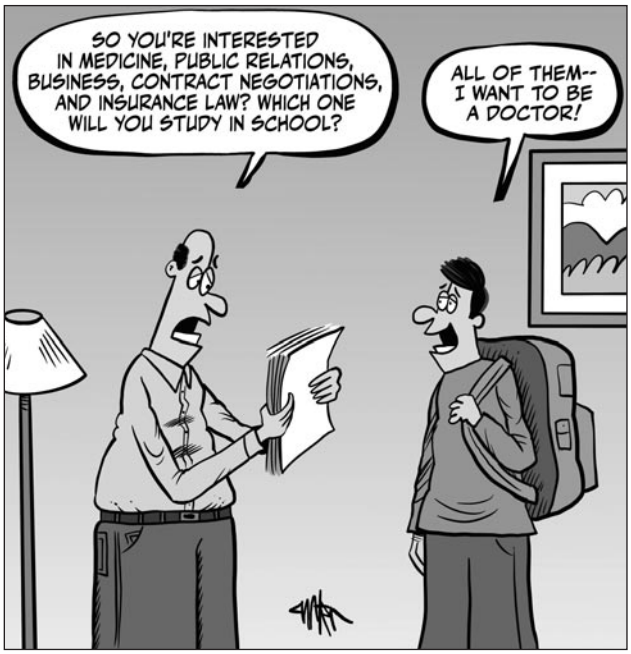


Illustration by Jon Carter, Courtesy Cartoonstock CS510308.

that NNMC struggles to retain and recruit. Allied health care providers like lab technicians, respiratory therapists, and phlebotomists are also in short supply at NNMC and across the state.

"State loan-repayment arrangements lure physicians to rural settings, but these physicians churn like lottery balls in a drum. The winning combination is a good doc who stays," Dr. Kovich explains.

The best long-term strategy to retain and recruit doctors and other allied medical providers is to "grow our own." Health care workers who grew up in New Mexico bring an invaluable understanding of our state's unique culture and history, which makes it easier for them to form relationships with their patients, many of whom are already friends, family, and neighbors. Because they already have roots here, they are often more likely to stay in the state for the long term.

Effective strategies for growing our own begin early, with middle and high school students. To get them started on pathways to careers in health care, the most promising avenue is to enhance health-care-related Career and Technical Education (CTE) programs in New Mexico's public schools, which give high school students opportunities to do hands-on work in clinics and hospitals and to shadow a variety of medical providers from doctors to lab technicians to EMTs.

Fortunately, in recent years New Mexico school districts, the legislature, and the PED have been bolstering CTE programs around the state,[12] increasing funding year over year. (One notable oversight is that, historically, that funding has not reached tribal schools or schools run by the Bureau of Indian Education, both of which should be included in any future expansions.)

As a result of the increased investment, 11,481 out of 151,013 — or about 8% of middle and high school students in New Mexico – took a health-care-related CTE course in the 2022 – 2023 school year, the last year for which data is available from the Public Education Department.

That percentage could be significantly higher, but for the fact that many medical clinics and hospitals in New Mexico are reluctant to host medical internships due to concerns about the risk of potential lawsuits when working with high school students. (While IHS facilities like NNMC are protected by the Federal Tort Claims Act, private health care institutions are not.)

This is a barrier that other states have successfully overcome with a couple of different approaches.

The cleanest approach is illustrated by a law passed in 2022 by the Kansas Legislature. That law simply provides liability protection to any entity, such as a medical clinic or hospital, that offers secondary school students a work-based learning program. The organization or person hosting the students is shielded from lawsuits for any injuries caused to or by students, except in cases of gross negligence or willful misconduct.

Another approach implemented by nine states from across the political spectrum (California, Indiana, Massachusetts, Minnesota, New Hampshire, New Jersey, Pennsylvania, South Carolina, and Vermont) is to enact a law requiring school districts to purchase insurance to cover students in work-based learning programs.

This reform would be particularly straightforward to accomplish in New Mexico, since 88 of the state's 89 school districts are insured through New Mexico's Public Schools Insurance Authority. This insurance purchasing cooperative could easily and cost-effectively provide this sort of insurance to districts across the state. (The only district that purchases its insurance separately is the state's largest, Albuquerque Public Schools, which has its own economies of scale.)

We recommend that the legislature and governor adopt one of these two approaches, which will open up more opportunities for middle and high school students in New Mexico to explore a career in a medical field.

A second impediment to growing our own health care workers is that New Mexico's health care-related CTE pathways often do not lead to a student earning a certification, such as the certifica-

12] In Think New Mexico's 2022 policy report, *A Roadmap for Rethinking Public Education in New Mexico*, we recommended that the state's high school graduation requirements should include two credits of CTE, since completing a two-credit CTE pathway has been shown to dramatically increase graduation rates and student success.

tion required to serve as an emergency medical technician, nursing assistant, or lab technician. Certifications matter because they allow students to immediately enter the job force, and they also make it more likely that the student will pursue additional education and more advanced credentials in a health care field.

In 2007, Florida enacted a law providing support to schools to help high school students earn employment certifications. Thirteen years later, an independent study of the program found that the policy had dramatically increased the number of high school students earning certifications, and that those students had higher rates of immediate enrollment in two-year college, as well as a higher likelihood of earning associates degrees.

We recommend that the legislature and governor direct the New Mexico Public Education Department to revise the state's health care CTE pathways so that more of those pathways result in a student earning a medical certification.

Grow More of Our Own I: Career & Technical Education

Past Progress

- **Significant investments in expanding access to CTE**

Further Recommendations

- **Provide liability protections for hospitals and medical centers that offer work-based learning opportunities for high school students**
- **Revise and strengthen health care related CTE pathways so that that more pathways lead to students earning a medical certification**

GROW MORE OF OUR OWN II: FINANCIAL INCENTIVES FOR FACULTY AND PRECEPTORS

While Career and Technical Education courses in high school can get students started on a path to a career as a health care worker, many of those paths require higher education. This offers another opportunity to grow more of our own, as health care workers often stay and practice in the state where they complete their training. For example, more than 40% of doctors currently practicing in New Mexico are graduates of the University of New Mexico School of Medicine or its residency program.

The good news is that New Mexico has already taken several major steps toward growing more of our own health care workers with investments in health-care-related higher education.

Progress Toward Growing More of Our Own

Between 2010–2020, the number of students enrolled in medical school in New Mexico increased by 208.1%, a larger increase than any other state in the nation. This includes students at both UNM School of Medicine and Burrell College of Osteopathic Medicine, a private, for-profit medical school located on the campus of New Mexico State University. Burrell College opened in 2013 and is responsible for most of the recent growth in the number of medical students. Burrell's most recent graduating class totaled 147 students. UNM School of Medicine currently enrolls around 100 students per year, and has set a goal of doubling that number to 200.

Due to this growth, New Mexico currently ranks 10th highest in the U.S. for the number of students enrolled in medical school relative to the state's overall population, according to the American Association of Medical Colleges. Around 90% of the medical students enrolled at UNM medical school are from New Mexico.

Once a student graduates from four years of medical school, they must then complete a residency. Residencies involve practicing under the close supervision of teaching doctors, and they last from three to seven years, depending on the specialty. Because the majority of doctors nationwide stay and practice where they complete their residency, many states, including New Mexico, have invested in creating additional residency slots. Between 2010–2020, UNM doubled the number of its primary care residency slots from 50 to 100.

In 2019, the legislature unanimously passed and Governor Lujan Grisham signed into law the Graduate Medical Education Expansion Grant Program Act to fund additional residency slots. The Act resulted in a five-year strategic plan to add 122 residency slots in a variety of high-need specialties across the state, from pediatrics to psychiatry. The Legislative Finance Committee estimates that these additional residencies should yield 34 new graduating residents per year, of which roughly half, or 17, would be expected to stay and practice in New Mexico. To date, the program has been funded with approximately $2 million annually.

New Mexico lawmakers have also invested in improving the state's retention of residents, which has long trailed the national average. While 57% of residents nationally stay and practice in the state where they complete their residency, in New Mexico that number has been just 21%. One major factor has been the low pay for residents, which hovered just above the state's minimum wage. During the 2024 session, legislators and the

governor appropriated $3.4 million to raise the pay for medical residents into the top half of U.S. residency programs.

Beyond the medical school and residencies, state lawmakers have also increased the funding available for other health care worker training programs. For example, in 2022 and 2023, lawmakers appropriated a total of $55 million of one-time funding and $9 million in recurring funding to increase the number of nursing education slots by approximately 400 annually.

Despite these substantial investments, the critical bottleneck in growing even more of our own medical workers has been a persistent shortage of faculty. As of July 2024, UNM had 71 nursing faculty on staff — of whom about half were already eligible for retirement — and 26 faculty vacancies. Dr. Douglas Ziedonis, CEO of the UNM Health System, testified to state lawmakers that "student body growth cannot be increased any further due to faculty constraints."[13]

This critical shortage of medical faculty can be alleviated with two smart investments.

Average Faculty vs. Practitioner Salaries in NM

Med School Faculty	$158,450
Family Doctor	$221,010
Nursing School Faculty	$72,850
Nurse	$92,140

Source: U.S. Bureau of Labor Statistics. State Occupational Employment and Wage Estimates. May 2023.

Make Faculty Salaries More Competetive

The biggest challenge to recruiting faculty is that health care professionals can generally earn significantly higher salaries practicing than teaching. For example, according to data from the U.S. Bureau of Labor Statistics, the annual average salary of a medical school professor in New Mexico is $158,450. By contrast, the average annual salary of a doctor in family practice in New Mexico is $221,010 — nearly 40% higher.

This wide gulf in salaries underscores that the most effective strategy for growing more of New Mexico's own health care workers is to increase faculty salaries in all of the state's health care worker training programs.

UNM has requested that lawmakers consider appropriations that would elevate faculty salaries to the 50th percentile nationally. If lawmakers appropriate an additional approximately $20 million a year for the next nine years — over and above planned salary increases based on the state's compensation methodology for higher education faculty — New Mexico's health care faculty salaries could reach that 50th percentile target.

13] The other factor often cited as an obstacle is a shortage of physical infrastructure, the buildings and equipment needed to expand training programs. New Mexico lawmakers have an excellent opportunity right now to invest in that physical infrastructure, as the state continues to bring in record amounts of money for capital outlay or infrastructure investments. Those dollars could be prioritized to support infrastructure for health care workforce development.

States with Tax Credits for Health Care Preceptors

Alabama	Missouri
Colorado	Oklahoma
Georgia	Rhode Island
Hawaii	South Carolina
Maine	Utah
Maryland	

Source: Compiled by Think New Mexico.

Provide a Tax Credit for Preceptors

Along with full-time faculty, another essential element of training for doctors, nurses, and many other health care workers is shadowing fully trained professionals. The health care professionals providing this training are known as preceptors, and there is a growing national shortage of them.

Currently, New Mexico preceptors donate their time to teach the next generation, as do those in many other states. However, since 2014, eleven states have enacted laws providing tax credits to preceptors, including our neighbors in Colorado. These tax credits range from $1,000 to $10,000 a year, and some increase with the number of students that a preceptor takes on, up to a specified maximum (e.g., five students per year).

In 2018, the New Mexico Health Care Workforce Committee report recommended that New Mexico enact a similar tax credit for preceptors. Senator Ortiz y Pino, who long served as Chair of the Senate Health and Public Affairs Committee, has introduced several bills to implement this proposal.

Senator Ortiz y Pino's legislation proposed to offer preceptors a tax credit of $1,000 for each student they mentored, up to five ($5,000) per year. This would exactly parallel the preceptor tax credit implemented in Hawaii in 2018. It was estimated to cost just $2.7 million annually. Unfortunately, the tax credit for preceptors has not yet been included in any of the legislature's annual omnibus tax packages.

We recommend that lawmakers enact the legislation developed by Senator Ortiz y Pino and bring New Mexico in line with the growing number of states that offer a tax credit to incentivize more health care professionals to serve as preceptors.

Funding to increase health care faculty salaries and provide a tax credit for health care preceptors can come from the Health Care Trust Fund, which we propose in the final section of this report.

Grow More of Our Own II: Higher Education

Past Progress

- Increased the number of medical students in New Mexico by more than 200% from 2010–2020
- Grew other health care worker training programs
- Enacted the Graduate Medical Education Expansion Grant Program and $2 million annual investment in new residencies
- Appropriated $3.4 million to raise pay for medical residents

Further Recommendations

- Raise faculty salaries with a goal of reaching the 50th percentile
- Provide a tax credit of up to $5,000 for medical preceptors

IMPORT MORE INTERNATIONAL MEDICAL GRADUATES: THE TENNESSEE MODEL

Three decades ago, in 1994, U.S. Senator Kent Conrad was facing a problem: the rural areas of his home state of North Dakota were suffering from a serious shortage of physicians. Despite their best attempts, these communities could not attract or retain enough U.S.-born health care providers. So Senator Conrad decided to look abroad to supplement his state's health care workforce.

Many foreign-born medical school graduates had already been coming to the U.S. to complete their residencies on a J-1 visa, which was a program launched in 1961 to foster educational and cultural exchanges among nations. These international medical graduates currently make up about a quarter of all resident physicians. However, once they completed their graduate studies, these students had to return to their home countries for at least two years before applying for another visa if they wanted to return to the U.S.

Senator Conrad saw an opportunity to instead allow these newly trained physicians to serve in some of the most underserved parts of his and other states. He sponsored bipartisan legislation that has come to be known as the "Conrad J-1 Visa Waiver," which waived the requirement for international physicians to return home after their residencies. Instead, it allowed each state to host up to 20 international physicians who had just completed U.S. residencies. Those newly minted doctors would have to practice in a medical shortage area for a minimum of three years, and they could remain in the country as long as their employment in that area continued. The bill passed the Senate unanimously, the House 407-4, and was signed into law.

The program was rapidly embraced by states that needed more doctors. In 2002, Congress increased the number of Conrad J-1 waivers to 30 per state. New Mexico has consistently filled its 30 slots each year, with our state Department of Health dedicating staff and resources to helping applicants through the process and finding them placements in high-need communities.

It has proven to be a good investment: about 28% of the doctors who receive Conrad J-1 waivers nationwide are still practicing in medically underserved communities five years later, compared with just 11% of U.S. medical graduates who participate in programs to provide care in those areas. Today, about one in every four doctors practicing in the U.S. is an international medical graduate, according to data collected by the Educational Commission for Foreign Medical Graduates. The rates are even higher for some specialties, such as internal medicine (39%), neurology (31%), and psychiatry (30%).

Despite the success of the Conrad J-1 Waiver program, Congress has so far declined to expand it any further. So some states are now piloting a creative new strategy to bring in more international doctors.

Many doctors come to the U.S. from other countries fully trained, having completed both medical school and the equivalent of a medical residency in their home country. Some have practiced medicine for years. However, these doctors are currently

not allowed to practice in the U.S. until they complete another residency here—a daunting requirement, considering that there are not even enough residency slots for graduates of U.S. medical schools. Nationally, about 8,000 immigrant physicians apply for U.S. residencies each year, and about 42% find a spot. As a result, these doctors are unable to use their medical training, and often end up working in fields unrelated to health care.

In 2023, Tennessee enacted a law allowing immigrant doctors who completed their residencies abroad to bypass the requirement of completing a U.S.-based residency. Instead, these doctors may receive a provisional medical license and practice under the supervision of a Tennessee physician for two years. Following the successful completion of that supervised period, they would be eligible to apply for a full, unrestricted medical license.

The Tennessee law was based on similar programs that have been successfully implemented in Canada and the United Kingdom. It includes a number of safeguards to ensure the quality of care, including that participants must be certified by the Educational Commission for Foreign Medical Graduates and pass Step 1 and Step 2 of the U.S. Medical Licensing Exams, which evaluate a person's understanding of the concepts and practice of medicine. (Students in U.S. medical schools generally complete these exams during their second and fourth years of study.)

Tennessee's law took effect on July 1, 2024, and is currently in the initial phase of implementation. Other states are following Tennessee's lead. In the last two years, bills to start similar programs have been introduced in Arizona, Iowa, Massachusetts, Missouri, Nevada, Vermont, and Wisconsin, and successfully enacted in Illinois, Florida, and Virginia.

We recommend that New Mexico lawmakers monitor the implementation of these laws in the first wave of states that has enacted them, and strongly consider following suit here and allowing doctors trained abroad to receive a provisional license without having to complete a U.S.-based residency.

Not only does this innovative program offer the opportunity to increase the number of trained doctors in our state within a short span of time, it also offers the potential to bring in doctors who have similar linguistic and cultural backgrounds to many of New Mexico's underserved communities, such as those who speak Spanish as a first or only language.

International Medical Graduates

Past Progress

- **New Mexico consistently fills its 30 Conrad J-1 visa slots with doctors educated abroad**

Further Recommendations

- **Allow internationally-trained doctors to apply for a provisional license to practice in New Mexico without having to complete a U.S.-based residency**

ESTABLISH A $2 BILLION PERMANENT FUND FOR HEALTH CARE

Legislators today rightly describe the 1973 law that created New Mexico's Severance Tax Permanent Fund (STPF) as one of the most visionary and impactful pieces of legislation passed in the 112 years since statehood.

The STPF is a fund in which the state deposits "receipts from taxes levied upon natural resource products severed and saved from the soil" (e.g., oil, gas, hardrock minerals). It functions as a sort of endowment that generates a perpetual funding stream to help pay the costs of state government, especially when those natural resources are fully depleted and no longer producing tax revenue.

Remarkably, the legislation that created the STPF was just a two-page bill with a relatively modest initial appropriation of $7 million. It passed during an oil boom in New Mexico in 1973 when legislative leaders decided it would be wiser to set aside some of the surplus revenue for future generations of New Mexicans rather than to spend it all as it flowed into state coffers.

In 1976, voters agreed, and to protect the fund from being raided, they enshrined the STPF into the state constitution, with more than 60% voting in favor.

A half century later, at the end of June 2024, the STPF had grown from that initial $7 million to $9.7 billion — a 138,186% increase from inception — thanks to prudent investment by the State Investment Council and annual deposits of severance tax revenue by the legislature.[14]

The STPF has not just grown exponentially; it has also paid out billions of dollars in distributions over the last half-century. Currently, annual distributions of 4.7% of the balance (based on a five-year rolling average) are made to: 1) New Mexico's General Fund, which pays for the state's annual budget; and 2) public school construction, water projects, and infrastructure projects, including tribal infrastructure projects.

Without the STPF, the legislature would need to raise taxes on citizens by nearly $500 million annually to pay for these projects and maintain current spending levels.

The success of the STPF may explain why it has become a model for a half dozen other states that are rich in natural resources. Alaska, Montana, North Dakota, Utah, West Virginia, and Wyoming all established similar funds in the years after the New Mexico legislature created the STPF.

With oil and gas reserves a half-century closer to peak production, the legislature has wisely taken advantage of the most recent oil and gas boom in the Permian Basin to create several new funds modeled after the STPF.

For instance, in the 2024 session, the legislature created the Higher Education Trust Fund with an initial appropriation of $959 million, as well as a Capital Development and Reserve Fund with an initial appropriation of $500 million. In 2023, the legislature established the Conservation Legacy

14] Inflows to the STPF vary widely, from as much as slightly more than $1 billion in 2022 to as little as $38.00 in 2017, as the legislature occasionally intercepts revenue that would otherwise reach the STPF.

New Mexico's Permanent Funds

FUND NAME	YEAR CREATED	BALANCE AT INCEPTION	BALANCE IN JUNE 2024	TOTAL DISTRIBUTIONS
Land Grant Permanent Fund*	**1912**	**$1.2 million**	**$31.4 billion**	**$18 billion**
Severance Tax Permanent Fund	**1973**	**$7 million**	**$9.7 billion**	**$7 billion**
Tobacco Settlement Permanent Fund	**1999**	**$49 million**	**$366 million**	**$884 million**
Water Trust Fund	**2001**	**$40 million**	**$148 million**	**$68 million**
Tax Stabilization Reserve Fund	**2017**	**$527 million**	**$2.2 billion**	**$0**
Rural Libraries Endowment Fund	**2019**	**$1 million**	**$32.7 million**	**$1.1 million**
Early Childhood Education & Care Fund	**2020**	**$300 million**	**$7.2 billion**	**$450 million**
Conservation Legacy Permanent Fund	**2023**	**$50 million**	**$354 million**	**$0**
Opioid Settlement Restricted Fund	**2023**	**$77 million**	**$78 million**	**$16 million**
Workforce Development & Apprenticeship Trust Fund	**2024**	**$30 million**	**$30 million**	**$5 million**
Higher Education Trust Fund	**2024**	**$959 million**	**$969 million**	**$48 million**
Capital Development & Reserve Fund	**2024**	**$476 million**	**$476 million**	**$0**

*Land Grant Permanent Fund starting value and total distributions are estimates, as not all data is available from early years.

Source: New Mexico State Investment Council. Personal Communication & *General Updates from the State Investment Council & Projected Growth of Permanent Funds & Distributions*. May 15, 2024.

Permanent Fund with $50 million and added $300 million more in 2024. Other recently created permanent funds are the Tax Stabilization Reserve Fund (2017) and the Early Childhood Education and Care Fund (2020). Additional funds range from the Workforce Development and Apprenticeship Trust Fund to the Water Trust Fund to the Rural Libraries Endowment Fund.

As Senate Finance Chair George Muñoz (D-Gallup), House Appropriations and Finance Chair Nathan Small (D-Las Cruces), and Department of Finance and Administration Secretary Wayne Propst wrote in an August 2024 opinion editorial, these funds represent an unprecedented level of savings that will ensure that important programs will be securely funded long into the state's future.

There is not yet, however, a permanent fund to address New Mexico's massive health care needs, even though health care is the second largest annual expense in New Mexico's budget after public education.

Such a permanent fund would play a key role in addressing the health care worker shortage. While some of the recommendations in this report will save taxpayer money, like malpractice reform, many of the other recommendations collectively carry an annual price tag of around $100 million. The legislature can pay for these reforms without raising taxes or reducing spending on other essential programs by creating a permanent fund for health care using some of the volatile revenues from the current oil and gas boom in New Mexico.

Cost of Reforms to Solve the Health Care Worker Shortage

Student Loan Repayment	$18.2 million
Rural Health Care Provider Tax Credit	$ 8.9 million
Medicaid Reimbursements	$50.0 million
Preceptor Tax Credit	$ 2.7 million
Health Care Faculty Salary Increases	$20.2 million
TOTAL	$100 million

Source: Compiled by Think New Mexico.

New Mexico's oil and gas tax revenue has more than quadrupled since 2019, growing to $15.2 billion in the current budget year according to the Legislative Finance Committee (LFC). Those revenues should grow even larger next year, as the LFC's most recent tracking report shows that income from oil and gas was 16.9% higher in January 2024 than it was in January 2023. The most recent revenue projections indicate that 2026 revenues will be about $2.5 billion higher than the state's recurring expenditures.

We recommend setting aside $2 billion of that budget surplus to create a permanent fund for health care to benefit New Mexicans in perpetuity. At a 5% yield, such a fund would yield $100 million annually to address both the reforms outlined in this report as well as other critical health care needs.

Creating a trust fund for health care is not a new idea. There have been multiple attempts by various legislators to create a Medicaid Trust Fund. The most recent attempt, sponsored by Senate Finance Chair George Muñoz (D-Gallup) in 2024, would have created a $1 billion trust fund to help cover the state's Medicaid costs. A $2 billion Permanent Fund for Health Care could be designed to fund not only Medicaid but also additional reforms designed to alleviate the medical shortage.

If half of the yield, or around $50 million, is used for Medicaid, that will bring in approximately $150 million in federal match, generating $200 million in health care spending in the state.

The legislature should also consider setting aside a portion of the trust fund distribution for tribal efforts to alleviate the health care worker shortage impacting Native New Mexicans, along the lines of the proposed Tribal Education Trust Fund.

No matter how the yield is distributed, by banking some of the state's surplus now, the legislature can create a new income stream that will reduce New Mexico's dependence on oil and gas revenue in the near term while preparing for a future when these natural resources are depleted and no longer producing tax revenue.

The critical shortage of health care providers in New Mexico makes creating a Permanent Fund for Health Care, patterned after the STPF, a particularly urgent priority.

Health Care Trust Fund

Past Progress

- Creation of many state trust funds

Further Recommendations

- Create a $2 billion permanent trust fund for health care

CONCLUSION

Solving the health care worker shortage will not only improve the health of New Mexicans — it will also benefit the state in a variety of other, perhaps unexpected ways.

One such benefit is expanding opportunities for economic development. The state's current shortage of health care professionals discourages companies from forming, relocating to, or remaining in New Mexico. Increasing the number of doctors, nurses, EMTs, physician assistants and others will reverse that trend and boost the economy.

For example, in July 2023, the Air Force announced that about 300 military personnel would be transferred from Cannon Air Force Base in Clovis to a base in Arizona. Cannon is the largest employer in Clovis, and this loss of personnel will negatively impact the local economy. The announcement came in the wake of the Air Force struggling to find enough health care professionals to serve the personnel stationed at Cannon. New Mexico's congressional delegation expressed concerns that families were having to travel four to five hours to access care in Albuquerque, Lubbock, or Amarillo. On average, military families at Cannon were traveling 147 miles to receive care — 30 miles to even reach a pharmacist. Without a more robust supply of health care workers, Cannon will not be able to meet the medical needs of its personnel, and New Mexico risks losing more of them to other states, further hollowing out the local economy.

On the flip side, the reforms recommended in this report will yield a remarkable return on investment. According to the 2018 Economic Impact Study from the American Medical Association, every doctor in New Mexico generates $1.9 million in annual economic output and supports an average of 11 jobs, resulting in $930,000 in wages and benefits and over $75,000 in state and local tax revenues.

Last summer, New Mexico House Speaker Javier Martínez summed up the situation in this way: "New Mexico must make a generational commitment as a state to train, develop, educate and retain health care professionals, not just medical doctors, but all the way to clinical social workers, nurses, pharmacists."

As we take up this generational challenge, we should be encouraged by the fact that, as discussed in the history section of this report, we have been able to make great strides in increasing access to health care in our state in earlier eras, and we can do so again.

By implementing the policies laid out in this report, we can halt the loss of doctors and other health care workers, and, over the long term, reverse the trend. If we succeed, in the years to come, communities across the state will be pleasantly surprised by the opening of maternity care departments and the availability of a wide variety of specialists in their hospitals, rather than the loss of these services, and New Mexico will become a model for other states in how to recruit and retain a robust health care workforce.

SELECTED BIBLIOGRAPHY

Introduction

Albuquerque Journal. "NM lawmakers need to stop doctor exodus to resuscitate health care system." February 11, 2023.

"Alta Vista regional hospital closes labor and delivery unit." News Release. June 24, 2022.

Association of American Medical Colleges. "Percentage Change in the Number of Active Physicians by Specialty, 2016–2021."

Boetel, Ryan. "Doctors flee New Mexico—and more are expected to follow." *Albuquerque Journal*. February 5, 2023.

Childress, Marjorie. "Lawmakers tackled New Mexico's crisis of rural health care workers. It wasn't enough." *New Mexico In Depth*. October 14, 2023.

Foster, Brody. "New research shows population decline in New Mexico's future." *Albuquerque Business First*. June 14, 2024.

Heild, Colleen. "NM faces hurdles recruiting doctors." *Albuquerque Journal*. February 24, 2019.

Matlock, Staci. "Rural health care gaps complicate pregnancies for New Mexico women." *Santa Fe New Mexican*. April 30, 2016.

McKay, Dan. "Governor turns her focus to health care." *Albuquerque Journal*. April 20, 2019.

McKay, Dan. "Lawmakers focus on doctor shortage." *Albuquerque Journal*. February 25, 2023.

McKay, Dan. "New Mexico hospitals cite financial pressure and care 'deserts' as they brief lawmakers on rural challengers." *Albuquerque Journal*. August 24, 2023.

Montoya Bryan, Susan. "New Mexico nursing shortage prompts call for more funding." Associated Press. January 27, 2022.

National Center for Health Workforce Analysis. Workforce Projections Dashboard. Accessed July 2, 2024.

New Mexico Health Care Workforce Committee. 2023 Annual Report. October 1, 2023.

"NM has nation's 2nd highest pharmacy shortage." *Taos News*. May 8, 2024.

Rural Health Information Hub, 2023. "Health Professional Shortage Areas: Primary Care, by County, 2023, New Mexico."

Sánchez, Vanessa G. "Maternal health crisis in New Mexico: services shrink, risks grow." *Searchlight New Mexico*. April 18, 2023.

Sánchez, Vanessa G. "Where have all the doctors (and nurses) gone?" *Searchlight New Mexico*. February 8, 2023.

Zhang, Xiaoming, Daniel Lin, Hugh Pfosich, and Vernon Lin. "Physician forecasting in the United States: forecasting nationwide shortages." *Human Resources for Health*. 18:8. 2020.

History & Tribal Health Care

Associated Press. "Medical school loses appeal, enrollment." *Albuquerque Tribune*. August 26, 1988.

Bargfeld, Laura. "Healing through culture: Increasing access to Native practices to treat mental health." *Source New Mexico*. November 22, 2022.

Borenstein, Seth. "Aging boomers could meet doctor shortage." *Albuquerque Journal*. December 14, 2000.

Boyle, Molly. "A Deeply Practical Magic." *New Mexico Magazine*. April 3, 2024.

Butler, Samuel W. The Medical Register and Directory of the United States. Office of the Medical and Surgical Reporter. 1874.

Dalen, James E. "The moratorium on US medical school enrollment from 1980 to 2005: what were we thinking?" *The American Journal of Medicine*. Vol. 121, No. 2. February 2008.

Davis, Deborah. "Medical crisis? Overwork, meager pay, taxation and red tape contribute to the shortage of specialists in New Mexico." *Santa Fe New Mexican*. November 4, 2001.

"Doctor Shortage," *Albuquerque Journal*, December 28, 1942.

Eastman, Clyde, Kathryn Renner, N. Scott Urquhart and Garrey E. Carruthers. *Use and Adequacy of Health-Care Services in New Mexico*. NMSU Research Report #320. May 1976.

Report of the Graduate Medical Education National Advisory Committee (GMENAC) to the Secretary, Department of Health And Human Services. September 30, 1980.

Health Education Division, New Mexico Department of Public Health. *A Chronological Outline of Selected Public Health Developments in New Mexico 1901–1954*.

Heild, Colleen. "Need a Doc? Take a Number. NM physician shortage means longer wait times, access challenges." *Albuquerque Journal*. January 12, 2014.

Indian Health Service. "Indian Health Disparities." October 2019.

Indian Health Service. "Shiprock-UNM Family Medicine Residency: About the Program."

Indian Health Service. Gold Book: The First 50 Years of the Indian Health Service.

Legislative Finance Committee. "Doctor shortage expected to get worse with reform." *LFC Newsletter*. February–May 2013.

Leary, Warren E. "1,000 hospitals will be paid to reduce supply of doctors." *New York Times*. August 25, 1997.

National Indian Health Board. "Indian Health Care 101." July 2014.

Ollove, Michael. "Doc shortage next hurdle for the ACA." Albuquerque Journal. January 12, 2014.

Quigley, Winthrop & Jackie Jadrnak. "Diagnosis? Chronic frustration. New Mexico doctors criticize low pay, but it's unclear whether more are leaving the state." *Albuquerque Journal*. October 29, 2000.

TAKE ACTION! Visit www.thinknewmexico.org and sign up for email alerts to join the effort to solve New Mexico's health care worker shortage!

Spidle, Jake W. Doctors of Medicine in New Mexico. UNM Press: Albuquerque. 1986.

U.S. Public Health Service. "Just by KEEPING WELL, You can help win this war!" *Albuquerque Tribune*, August 17, 1942.

Medical Malpractice

2023 Malpractice Report Data. National Practitioner Data Bank – Data Analysis Tool. U.S. Department of Health and Human Services.

2023 Medical Malpractice Financial Information: Annual Report. Florida Office of Insurance Regulation. October 1, 2023.

2024 Annual Report of the Patient Compensation Fund Advisory Board to the New Mexico Legislature. January 8, 2024.

American Medical Association. *State Laws Chart I: Liability Reforms*. 2024.

Chu, Vivian. *Medical Malpractice Liability Reform: Legal Issues and 50-State Surveys of Caps on Noneconomic and Punitive Damages and of Punitive Damages and of Punitive Damages Burden of Proof Standards*. Congressional Research Service. March 1, 2011.

Collingwood, Chris. "Medical malpractice court filings, insurance rates rise with venue shopping." *Lehigh Valley Business*. January 19, 2024.

Condon, Alan. "New Mexico hospital faces possible closure over $68M malpractice verdict." *Becker's Hospital Review*. May 31, 2024.

Guardado, José. *Prevalence of Medical Liability Premium Increases Unseen Since 2000s Continues for Fourth Year in a Row*. American Medical Association. 2023.

International Association of Defense Counsel. *50 State Medical Defense and Health Law Quick Guide*. 2016.

Kovnat, Ruth L. "Medical Malpractice Legislation in New Mexico." *New Mexico Law Review*. Winter 1977.

Lohmann, Patrick. "As Gallup hospital tries to mend financial wounds, it faces a $68 million judgment." *Source New Mexico*. May 16, 2024.

Lohmann, Patrick. "Gallup hospital says it is 'indigent' ahead of court order to find more than $100 million." *Source New Mexico*. May 31, 2024.

New Mexico Statutes Annotated, Sections 41-5-1 et. seq.

Office of the Superintendent of Insurance. Bulletin 2024–006. *Medical Malpractice Premium Reduction.* June 11, 2024.

Office of the Superintendent of Insurance. *Medical Malpractice Act/Patient's Compensation Fund Modification Report.* December 31, 2020.

Office of the Superintendent of Insurance. *New Mexico PCF Rate Analysis 2023*.

Smith, Doug. "Fewer medical malpractice suits." *Arkansas Times*. November 7, 2008.

Todd, Marianne. "Hospitals say New Mexico's rising malpractice payout cap puts insurance out of reach." *Santa Fe New Mexican*. September 3, 2023.

Wang, Yang, et. al. "The Relationships Among Cash Prices, Negotiated Rates, And Chargemaster Prices For Shoppable Hospital Services." *Health Affairs*. Vol. 42, No. 4. April 2023.

Interstate Compacts

Council of State Governments. National Center for Interstate Compacts.

Greenberg, Ben. "Multistate compacts are the cure for New Mexico's access-to-care crisis." *Albuquerque Journal*. March 18, 2023.

Grubs, Matt. "Doctor shortage continues in New Mexico: what are the next steps?" *KOB-TV*. December 8, 2023.

McKay, Dan. "Senate approves compact for nurses." *Albuquerque Journal*. January 18, 2018.

Natale, Naomi and Michael Casaus. "Our son with cancer needs the interstate medical compact." *Santa Fe New Mexican*. February 16, 2023.

New Mexico Medical Board. *Presentation to the Legislative Health and Human Services Committee Meeting*. July 2, 2024.

Senate Bill 186, 46th Legislature, First Session, 2003.

House Bills 247, 248, 249, 391, and 392, 56th Legislature, First Session, 2023.

Centralized Credentialing

Chenier, Eric and Rachel Garcia. *Behavioral Health Criminal Justice Services and Funding. Presentation to the Legislative Finance Committee*. July 15, 2024.

House Joint Memorial 61, 45th Legislation, Second Session, 2002.

New Mexico Health Policy Commission. *Standardize Licensing and Credentialing of Health Care Providers Study*. House Joint Memorial 61 (2002) Final Report. October 2002.

Porter, Gabrielle. "Despite some growth, NM's behavioral health system still lacking, analysts say." *Santa Fe New Mexican*. July 16, 2024.

Senate Bill 220, 52nd Legislature, First Session, 2015.

Senate Bill 232, 56th Legislature, First Session, 2023.

State of Arkansas. About the Centralized Credentials Verification Service. Accessed July 17, 2024.

Health Professional Student Loan Repayment

Hanson, Melanie. "Average Medical School Debt." *Education Data Initiative*. September 17, 2023.

Legislative Finance Committee. Review of HED Financial Aid Programs. Report #08-13. October 23, 2008.

Porter, Gabrielle. "Wanted: All types of health care providers, all over New Mexico." *Santa Fe New Mexican*. July 1, 2024.

Rodriguez, Stephanie M. "New Mexico Higher Education Department offering $14.6 million in debt relief for health care workers." *Los Alamos Daily Post*. March 20, 2024.

New Mexico Statutes Annotated, Sections 21-22D-1 et. seq.

Tax Reforms

Dannemann, Merilee. "A welcome relief on gross receipts tax." *Gallup Independent*. May 30, 2023.

Dumler, James R. "Where and when are medical services taxable?" April 11, 2017.

Gessing, Paul. *Solving New Mexico's Medical Professional Shortage*. Rio Grande Foundation. October 31, 2022.

House Bill 252, 56th Legislature, Second Session, 2024.

House Bill 547, 56th Legislature, First Session, 2023.

House Bill 625, 46th Legislature, Second Session, 2004.

House Bill 638, 48th Legislature, First Session, 2007.

Legislative Finance Committee. Select Healthcare Tax Expenditures. October 26, 2016.

New Mexico Medical Society. *Independent Physician Perspective on State Taxation of Medicine.* Presentation to the Revenue Stabilization & Tax Policy Committee. October 7, 2022.

New Mexico Taxation and Revenue Department. *2023 Tax Expenditure Report.*

New Mexico Taxation and Revenue Department. Gross Receipts and Compensating Tax Rate Schedule Effective July 1, 2024 through December 31, 2024.

New Mexico Taxation and Revenue Department. History of New Mexico's Taxes: Selected Taxes–1909–2000."

Roybal, Benjamin C. Gross Receipts Taxation of Selected Physicians Services. July 7, 2007.

Medicaid

Altarum Healthcare Value Hub. *Medicare Rates as a Benchmark: Too Much, Too Little or Just Right?* Research Brief #40. February 2020.

Alexander, Diane, and Molly Schnell. "The impacts of physician payments on patient access, use, and health." National Bureau of Economic Research. Working Paper 26095. July 2019.

Armijo, Kari, and Elisa Walker-Moran. *Medicaid Reimbursement Update.* Presentation from the New Mexico Human Services Department to the Legislative Health & Human Services Committee. July 11, 2023.

Caroll, Aaron E. "Why it's so hard to find a pediatrician these days." *New York Times*. July 1, 2024.

Clark, Troy. "Preserve funding for Medicaid as costs rise." *Albuquerque Journal*. April 23, 2023.

Dunn, Abe, et. al. "A denial a day keeps the doctor away." National Bureau of Economic Research. Working Paper 29010. January 14, 2023.

Flannery, Dana, and Alanna Dancis. Health Care Access. Presentation from the New Mexico Health Care Authority to the Legislative Health and Human Services Committee. July 2, 2024.

Grimm, Christi A. *High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care.* U.S. Department of Health and Human Services – Office of the Inspector General. OEI-09-19-00350. July 2023.

U.S. Census Bureau. *Health Insurance Coverage Status and Type by Geography: 2021 and 2022.* September 2023.

Mann, Cindy and Adam Striar. "How differences in Medicaid, Medicare, and commercial health insurance payment rates impact access, health equity, and cost." Commonwealth Fund. August 17, 2022.

KFF. Medicaid in New Mexico. June 2023.

Legislative Finance Committee. *2023 Accountability Report: Medicaid.*

Legislative Finance Committee. *Medicaid Network Adequacy, Access, and Utilization*. Report #22-06. December 13, 2022.

Narvaiz, Matthew. "Reimbursement rates for Medicaid increase." *Albuquerque Journal*. December 11, 2023.

National Governors Association. *Addressing Wages of the Direct Care Workforce Through Medicaid Policies*. November 2022.

Career & Technical Education

American Student Assistance & Bellweather Education Partners. *Working to Learn and Learning to Work: A state-by-state analysis if high school work-based learning policies.* March 2021.

Glennie, Elizabeth J., Randolph Ottem, and Erich Lauff. "The Influence of Earning an Industry Certification in High School on Going to College: The Florida CAPE Act." *Journal of Career and Technical Education*. Vol. 35, No. 1. 2020.

Kansas Statutes, Section 72-3824.

Kovich, Heather. "And how long will you be staying, doctor?" *New England Journal of Medicine*. 376:14. April 6, 2017.

National Conference of State Legislatures. *Leveraging Career Pathway Programs: State Strategies to Combat Health Care Workforce Shortages*. June 2023.

Witzen, B. Heath. "The Effects of Completing a Health CTE Program on College and Workforce Outcomes." Maryland Longitudinal Data System Center. December 2018.

Zinth, Jennifer Zinth. *Response to Information Request On Other States that have Enacted Legislation Around Work-based Learning Insurance and Liability Issues*. Education Commission of the States. October 2018.

Higher Education for Health Care Workers

Alfonso, Susana et. al. "Significant primary care preceptor shortage remains one year after the pandemic started." A*nnals of Family Medicine*. Vol. 21, Suppl. 1. 2023.

Association of American Medical Colleges. *Table A-1: U.S. MD-Granting Medical School Applications and Matriculants by School, State of Legal Residence, and Gender, 2023–2024.*

Berry, Alisha. "Ease doctor shortage: improve retention of residents." *Santa Fe New Mexican*. October 23, 2022.

Brunelle-Raja, Bethany. "Doña Ana County is leading New Mexico in a statewide shortage of registered nurses." *Las Cruces Sun News*. October 28, 2020.

House Bill 480, 54th Legislation, First Session, 2019.

Legislative Finance Committee. *Medicaid: Physical Health and Behavioral Health Workforce*. June 12, 2024.

Legislative Finance Committee. *Medicaid Network Adequacy, Access, and Utilization*. Report #22-06. December 13, 2022.

Legislative Finance Committee. *Nursing Expansion and Workforce*. July 16, 2020.

McKenzie, Paige. *The Existence and Extent of a Medical Provider Shortage in New Mexico*. Rio Grande Foundation. 2023.

Narvaiz, Matthew. "UNM resident physicians rally for better pay, benefits." *Albuquerque Journal*. October 5, 2023.

New Mexico Human Services Department. *Graduate Medical Education Expansion in New Mexico Five Year Plan.* December 2019.

Senate Bill 173, 55th Legislature, Second Session, 2022.

UNM School of Medicine. *2022 Location Report.*

UNM School of Medicine and College of Nursing. *Presentation to the Legislative Health and Human Resources Committee.* July 11, 2023.

U.S. Bureau of Labor Statistics. *State Occupational Employment and Wage Estimates.* May 2023.

Ziedonis, Douglas. *What UNM is Doing and Ideas for Expansion.* Presentation to the Legislative Health and Human Resources Committee. July 12, 2024.

International Medical Graduates

American Medical Association. "How IMGs have changed the face of American medicine." October 19, 2021.

Ester, Karma A. *Immigration: Foreign Physicians and the J-1 Visa Program.* Congressional Research Service Report RL31460. December 9, 2004.

Lewis, Thomas. "Importing Latin American nurses would be a good fit for New Mexico." *Albuquerque Journal*. March 31, 2024.

Peterson, Sarah K. "Flatlining care: why immigrants are crucial to bolstering our health care workforce." Testimony before the U.S. Senate Judiciary Subcommiteee on Immigration, Citizenship, and Border Safety. September 14, 2022.

Public Law No. 108-441. December 3, 2004.

Rampell, Catherine. "Path to United States practice is long slog for foreign doctors." *New York Times*. August 11, 2013.

Ramesh, Tarun, Marcela Horvitz-Lennon, and Hao Yu. "Opening the door wider to International Medical Graduates – The significance of a new Tennessee law." *New England Journal of Medicine*. 389:21. November 23, 2023.

Health Care Permanent Fund

Austria, Jon. "A look into New Mexico's new workforce trust fund." *Albuquerque Journal*. May 20, 2024.

Faubion, Jennifer. *Oil and Gas Revenue to the State of New Mexico*. Presentation to the Legislative Finance Committee. June 11, 2024.

Gleason, Megan. "Oil and gas delivered $15.2B for NM in FY23." *Albuquerque Journal*. June 11, 2024.

Grant County Beat. "House passed budget with $300 million for Land of Enchantment Legacy Fund." January 31, 2024.

House Joint Resolution 5, 32nd Legislature, First Session, 1975.

House Bill 501, 31st Legislature, First Session, 1973.

Jennings, Trip. "New Mexico Early Childhood Trust Fund flush with new revenue." *New Mexico In Depth*. August 30, 2021.

Legislative Finance Committee. *Legislating for Results: Policy & Performance Analysis*. January 2024.

Legislative Finance Committee. *Legislating for Results: Post-Session Review*. April 2024.

New Mexico Higher Education Department. "Governor signs bill creating $959M trust fund guaranteeing tuition-free college in NM." News Release. March 11, 2024.

New Mexico Statutes Annotated, Section 7-27-27.

Senate Bill 139, 56th Legislature, Second Session, 2024.

Swartz, Mimi. "The oil boom that went bust." *Texas Monthly*. May 2023.

Torres, Ismael. *Severance Taxes and the Permanent Fund.* Presentation to the Revenue Stabilization and Tax Policy Committee. October 6, 2022.

Wollman, Charles. *General Updates from the State Investment Council & Projected Growth of Permanent Funds and Distributions*. May 15, 2024.

Conclusion

"Air Force announces transfer of Cannon personnel, aircraft." July 31, 2023.

American Medical Association. *The National Economic Impact of Physicians.* January 2018.

Letter from New Mexico's Congressional Delegation to the Dr. Lester Martinez-Lopez, Assistant Secretary of Defense for Health Affairs and Major General Telita Crosland, Director, Defense Health Agency. June 7, 2023.

Givens, Alexcia. "Medical support summit brings senior leaders to Cannon." 27th Special Operations Wing Public Affairs. September 27, 2023.

McKay, Dan. "Bipartisan measures in the mix as lawmakers eye New Mexico's doctor shortage." *Albuquerque Journal*. February 24, 2023.

Muñoz, George, Nathan Small and Wayne Propst. "NM is growing unprecedented savings for the future." *Albuquerque Journal*. August 18, 2024.

Nichols, Meagan. "It's time to look at New Mexico's health care system as a business crisis." *Albuquerque Business First*. March 20, 2023.

www.thinknewmexico.org

505 Don Gaspar Ave. Santa Fe, New Mexico 87505
Phone: 505. 992.1315 Email: info@thinknewmexico.org