New Mexico Medical Board
Special Meeting

March 18, 2010
4:00 p.m.

AGENDA

1. Approve Agenda

2. Proposed Rule Change
   Business Entities – Authorized to Provide Healthcare Services"

3. Licensure Matters [portions may be closed*]
   - Consider request to reopen the case of Andrew Valencia under Section 61-1-12 (A) of the Uniform Licensing Act

4. HPC Physician Survey on 2010 Renewal

5. Adjourn

* "Pursuant to NMSA 1978, Section 10-15-1 (H) (1) of the Open Meetings Act, Sections 10-15-1 to 10-15-4, the Board of Medical Examiners may close portions of its meeting to discuss certain matters pertaining to a particular license. All final actions concerning a license will be made in an open meeting."

* "Pursuant to NMSA 1978, Section 10-15-1 (H) (2) of the Open Meetings Act, Sections 10-15-1 to 10-15-4, the Board of Medical Examiners may close portions of its meeting to discuss limited personnel issues."

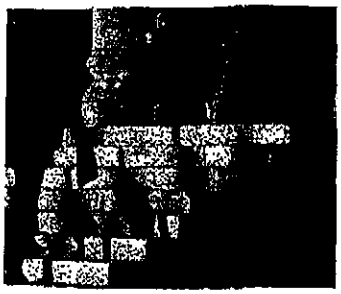
Initials in red are members recused in disciplinary cases

Business Entities—Authorization to Provide Healthcare Services

A. **Purpose**. The purpose of this regulation is to clarify and confirm that certain business entities are and have been authorized to provide healthcare services in New Mexico.

B. **Healthcare Services--Certain Business Entities**. A business entity formed pursuant to the laws of the state of New Mexico is authorized to provide healthcare services in the state of New Mexico if the healthcare services are provided by or under the direction of persons who are duly licensed to engage in the practice of medicine pursuant to the provisions of the Medical Practice Act.

C. **Retroactivity**. Pursuant to NMSA §12-2A-8, this regulation shall apply retroactively to _____.



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March 8, 2010

Via Facsimile Transmission & U. S. Mail

Steven Weiner, MD, Chair
New Mexico Medical Board
2055 South Pacheco Street
Building 400
Santa Fe, NM 87505

Re: In the Matter of Andrew Valencia
No. 2008-030

Dear Dr. Weiner:

I am the attorney for Andrew Valencia in the above referenced matter. I am in receipt of the Decision and Order of the Board signed by you on February 18, 2010. Although certified as a physician's assistant, Mr. Valencia has not practiced as such since the 1970s. As you are aware, the Board denied Mr. Valencia's application to practice as a physician's assistant on the basis of his alleged current lack of competency and training.

I have been charged with the task of seeking judicial review of the Board's Decision and Order. It has occurred to me that, given the stated basis for the Board's denial of Mr. Valencia's application, there may be another approach that could save both the Board and my office from expending unnecessary time and effort.

Since the issue is lack of a demonstration of competency, would the Board be willing to grant to Mr. Valencia a temporary, limited license solely for the purpose of permitting him to attempt to demonstrate his competency by working under the supervision of a licensed physician subject to terms and conditions set by the Board?

Given that time is of the essence, I would appreciate hearing back from you by March 15, 2010, so that I can file a timely notice of appeal, if necessary. Thank you for your consideration.

Very truly yours,

Paul F. Becht
PFB:hms

XC: Paul J. Kovnat, MD

Survey Questions

Instructions

In collaboration with New Mexico Health Policy Commission, the NMMB is initiating the below Physician Survey as a REQUIREMENT of the 2010, 2011 and 2012 renewal process. The purpose of the survey is to analyze physician supply and distribution in New Mexico.

Please answer every question below in a timely manner, if there is more than 30 minutes of inactivity, you will have to login and start the survey over again. We recommend that you print a copy of the survey by going HERE, and review it prior to completing it online.

PLEASE NOTE: you must complete the survey online to fulfill the renewal requirement, we will not accept the printed survey, this is for your review ONLY.

Question	Answer
1. CURRENT WORK STATUS IN MEDICINE • 1A. Mark all that apply: * If you are a current resident or fellow, please answer the remaining questions, as they relate to non-residency training activity	☐ Practice Medicine in NM ☐ Practice Medicine in TX ☐ Practice Medicine in CO ☐ Practice Medicine in AZ ☐ Practice Medicine in Other ☐ Permanently or Temporarily Inactive in Medicine ☐ Retired, but maintain an active license ☐ Retired and do not maintain an active license ☐ Current Resident or Fellowship Training*
2. CURRENT ACTIVITIES IN MEDICINE IN NEW MEXICO • 2A. How many weeks per year do you practice medicine in NM?	Please Choose
• 2B. How many Hours per week do you actively practice medicine in NM?	Please Choose
For your New Mexico medical practice, approximately what percent of your time reported in 2B above was spent in the following activities (Percentages should total 100%): • 2C. Direct Patient Care:	Please Choose
• 2D. Research:	Please Choose
• 2E. Teaching/Precepting:	Please Choose
• 2F. Healthcare Admin.:	Please Choose
• 2G. Other:	Please Choose
• 2H. If you selected from Other in 2G above please specify:	
For Direct Patient Care, approximately what percent of your time, reported in question 2C above, was spent in the following types of facilities (percentages should total the percent reported in 2C above)? • 2I. Hospital/Inpatient	Please Choose
• 2J. Outpatient/Clinic	Please Choose
• 2K. Other	Please Choose
• 2L. If you selected "Other" in 2K above, please specify:	
3. LOCATION OF EDUCATION AND TRAINING • 3A. Location of the high school from which you graduated:	Please Choose
• 3B. Location of the Medical School from which you graduated:	Please Choose
• 3C. Location of Primary Specialty Training:	Please Choose
• 3D. Location of Secondary Specialty Training:	Please Choose
4. & 5. PRACTICE SPECIALTY(IES) IN WHICH YOU SPEND MOST OF YOUR	

PROFESSIONAL TIME	
• 4A. Select ONE Primary Specialty:	Please Choose
• 4B. If you selected "Other" in 4A above please specify:	
• 4C. If Applicable Select ONE Secondary Specialty:	Please Choose
• 4D. If you selected "Other" in 4C above, please specify:	
• 5A. Percentage of your patient care time spent in your PRIMARY specialty (percentages of questions 5A and 5B should total 100%):	Please Choose
• 5B. Percentage of your patient care time spent in your SECONDARY specialty (percentages of questions 5A and 5B should total 100%):	Please Choose
6. TRAINING AND CERTIFICATION	
• 6A. Completed Accredited Residency Program in PRIMARY Specialty:	Please Choose
• 6B. Board Certified/Certificate of Added/Special Qualification in PRIMARY Specialty:	Please Choose
• 6C. Completed Accredited Residenty Program in SECONDARY Specialty:	Please Choose
• 6D. Board Certified/Certificate of Added/Special Qualification in SECONARY Specialty:	Please Choose
7. HOSPITAL ADMITTING PRIVILEGES	
• 7A. Number of hospitals in New Mexico at which you have admitting privileges:	Please Choose
8. REIMBURSEMENT: PAYMENT SOURCES (percentages of 8C through 8H should total 100%) COMPENSATED CARE • 8A. Primary Source of payment for patient care (select top three).	☐ Medicare ☐ Medicaid ☐ Trycare/VA/IHS ☐ Private Insurance ☐ Self-Pay ☐ Bad Debt/Charity ☐ Other
• 8B. If you selected "Other" in 8A above, please specify.	
• 8C. What percent of your patients have MEDICARE as their primary source of payment?	Please Choose
• 8D. What percent of your patients have MEDICAID as their primary source of payment?	Please Choose
• 8E. What percent of your patients have TRICARE/VA/IHS as their primary source of payment?	Please Choose
• 8F. What percent of your patients have PRIVATE INSURANCE as their primary source of payment?	Please Choose
• 8G. What percent of your patients SELF PAY?	Please Choose
• 8H. What percent of your patients have BAD DEBT/CHARITY/OTHER as their primary source of payment?	Please Choose
UNCOMPENSATED CARE	
• 8I. Provide the approximate monetary value of the UNCOMPENSATED patient care you provided during the last calendar year for EMERGENCY SERVICES:	Please Choose
• 8J. Provide the approximate monetary value of the UNCOMPENSATED patient care you provided during the last calendar year for NON-EMERGENCY SERVICES:	Please Choose
9. PATIENT CARE PRACTICE LOCATIONS Location of site where you spend the most time providing PATIENT CARE. Enter the address of your PRIMARY PRACTICE LOCATION including the 5-digit zip code. For your secondary practice location, please enter the 5-digit zip code only. Also indicate the average hours per week you spend at each location and the average number of patient encounters you have per week at each practice location. PRIMARY LOCATION • 9A. PRIMARY Patient Care Street Address:	
• 9B. PRIMARY Patient Care City/Town:	
• 9C. PRIMARY Patient Care State:	Please Choose
• 9D. PRIMARY Patient Care 5-digit Zipcode:	

• 9E. Weekly PRIMARY Patient Care Hours:	Please Choose
• 9F. Weekly PRIMARY Number of Patients:	Please Choose
SECONDARY LOCATION	
• 9G. SECONDARY Patient Care 5-digit Zipcode:	
• 9H. Weekly SECONDARY Patient Care Hours:	Please Choose
• 9I. Weekly SECONDARY Number of Patients:	Please Choose
PRACTICE SETTINGS	
• 9J. What best describes your PRIMARY location practice and practitioners?	Please Choose
• 9K. What best describes your SECONDARY location practice and practitioners?	Please Choose
• 9L. What best describes your PRIMARY location practice type and ownership?	Please Choose
• 9M. If you chose Organizationally affiliated employed physician in 9L above please specify the organization/practice group (e.g. UNM, Albuquerque Health Partners, Presbyterian, etc.).	
• 9N. If you chose Other in 9L above please specify your PRIMARY location practice type:	
• 9O. What best describes your SECONDARY location practice type and ownership?	Please Choose
• 9P. If you chose Organizationally affiliated employed physician in 9O above please specify the organization (e.g. UNM, Albuquerque Health Partners, Presbyterian, etc.):	
• 9Q. If you chose Other in 9O above please specify your SECONDARY location practice type:	
10. CURRENT PRACTICE CAPACITY	
• 10A. Which best describes your patient care practice capacity?	Please Choose
11. ELECTRONIC MEDIA USE IN MEDICAL PRACTICE	
• 11A. Does your practice CURRENTLY have the following capabilities? (select all that apply)	☐ Electronic health record ☐ E-Prescribing ☐ E-labs (order and receive) ☐ X-Ray and Imaging (order and receive) ☐ Telemedicine
• 11B. Does your practice plan to have in the next year the following capabilities? (select all that apply)	☐ Electronic health record ☐ E-Prescribing ☐ E-labs (order and receive) ☐ X-Ray and Imaging (order and receive) ☐ Telemedicine
• 11C. If your practice provides electronic health records, does it provide a personal health record/patient portal?	Please Choose

12. REFERRAL DIFFICULTIES • 12A. Identify the specialties that you or your patients have the greatest difficulty scheduling/obtaining/arranging a timely appointment when making referrals (MARK UP TO 3 SPECIALTIES):	☐ Allergy and Immunology ☐ Anesthesiology ☐ Dermatology ☐ Emergency Medicine ☐ Family Medicine ☐ General Practice ☐ Internal Medicine: General ☐ Internal Medicine: Cardiovascular Disease ☐ Internal Medicine: Critical Care Medicine ☐ Internal Medicine: Endocrinology and Metabolism ☐ Internal Medicine: Gastroenterology ☐ Internal Medicine: Geriatrics ☐ Internal Medicine: Infectious Disease ☐ Internal Medicine: Nephrology ☐ Internal Medicine: Oncology/Hematology ☐ Internal Medicine: Pulmonary Disease ☐ Internal Medicine: Rheumatology ☐ Internal Medicine: Other/Sub-Specialty ☐ Neurology ☐ Obstetrics and Gynecology ☐ Gynecology (only) ☐ Occupational Medicine ☐ Ophthamology ☐ Otolaryngology ☐ Pathology (General) ☐ Pathology Sub-Specialty ☐ Pediatrics (General) ☐ Pediatrics Sub-Specialty ☐ Physical Medicine and Rehabilitation ☐ Preventive Medicine ☐ Psychiatry: Adult ☐ Psychiatry: Child and Adolescent ☐ Radiology: Diagnostic ☐ Radiology: Therapeutic ☐ Surgery: General ☐ Surgery: Neurological ☐ Surgery: Orthopedic ☐ Surgery: Plastic ☐ Surgery: Thoracic ☐ Surgery: Other/Sub-Specialty ☐ Urology ☐ Other
• 12B. If you selected "Other" in 12A above, please specify which specialty:	
13. RECRUITMENT EXPERIENCES How would you describe your experience in recruiting: • 13A. Physicians:	Please Choose
• 13B. Nurses:	Please Choose
• 13C. Nurse Practitioners:	Please Choose
• 13D. Physician Assistants:	Please Choose
• 13E. Other Health Professionals:	Please Choose
14. GENDER	

• 14A. What is your gender?	Please Choose
15. RACE/ETHNICITY • 15A. What is your ethnicity?	Please Choose
• 15B. What is your race? (Select all that apply):	☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ Black/African American, (non-hispanic) ☐ Hispanic/Latino ☐ White, (non-hispanic) ☐ Other
• 15C. If you chose "Other in 15B above, please specify:	
16. NEAR FUTURE PRACTICE PLANS • 16A. In the next 12 months, I plan to: (Mark all that apply)	☐ Retire From Patient Care ☐ Significantly Reduce Patient Care Hours ☐ Move My Practice to Another Geographic Location in New Mexico ☐ Move My Practice Out of New Mexico ☐ None of the Above
• 16B. If you are retiring, moving, or reducing your patient care hours in the next 12 months, what are the factors that led to this decision? (Mark all that apply):	☐ Age ☐ General Lack of Job Satisfaction ☐ Geographic Preference ☐ Gross Reciepts Tax ☐ Health ☐ Increasing Administrative/Regulatory Burden ☐ Practice Environment ☐ Reimbursement Issues ☐ Other
• 16C. If you seleced "Other" in 16B above, please specify:	
17. PROFESSIONAL LIABILITY INSURANCE INCREASE THRESHOLDS At what percent increase in your annual professional liability insurance premium above your current level would you consider? Choose all that apply from your answers in 16 above. • 17A. Retiring from patient care:	Please Choose
• 17B. Significantly reducing my patient care hours:	Please Choose
• 17C. Moving practice out of state:	Please Choose
18. MEDICARE PAYMENT DECREASE THRESHOLDS At what percent decrease in your Medicare payment level would you consider? Choose all that apply. • 18A. Retiring From Patient Care:	Please Choose
• 18B. Closing My Practice to New Medicare Patients:	Please Choose
• 18C. Closing My Practice to All Medicare Patients:	Please Choose
• 18D. Significantly Reducing My Patient Care Hours:	Please Choose
• 18E. Moving Practice Out of State:	Please Choose