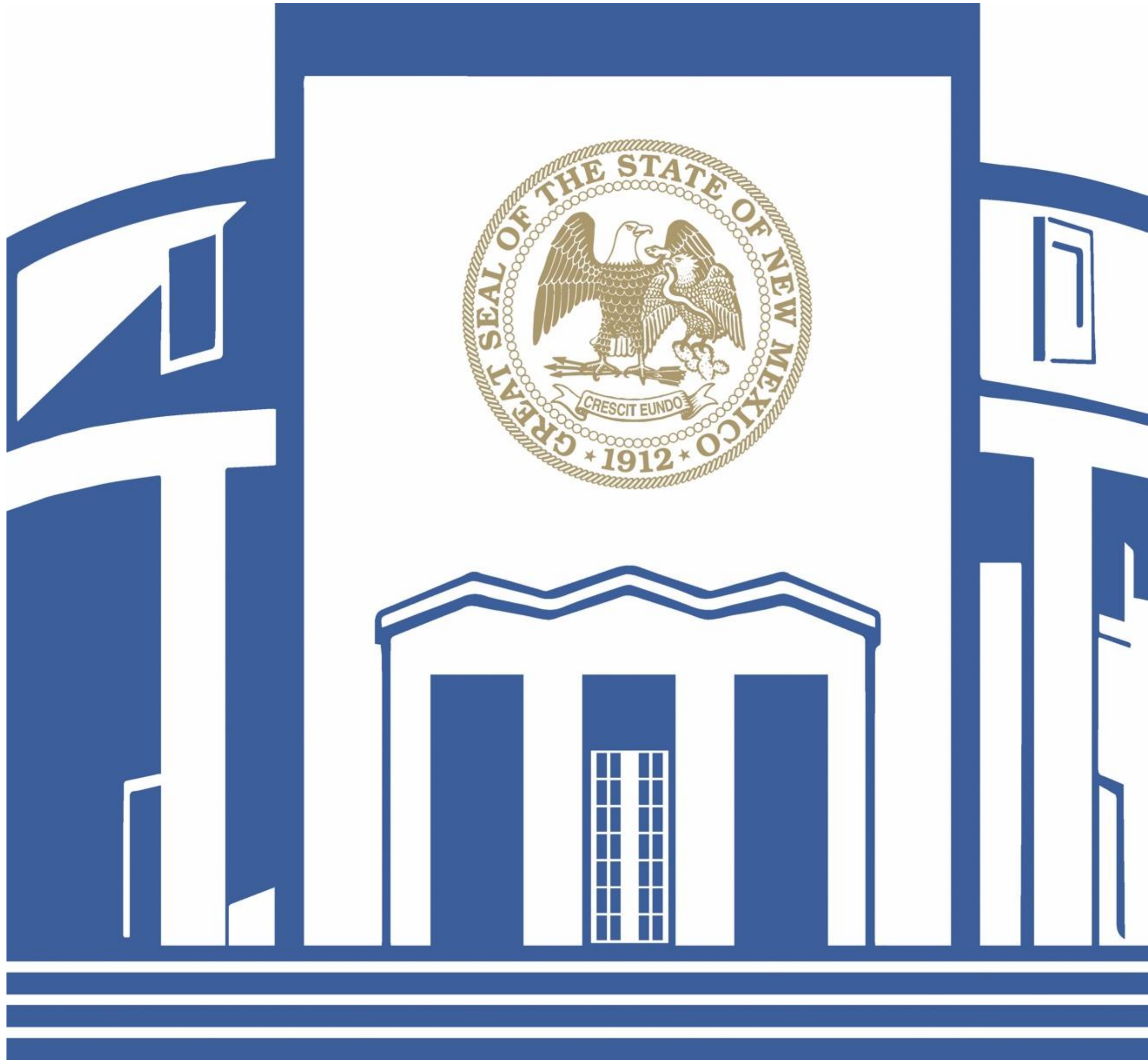

Evaluation of Opportunities for New Mexico Pharmaceutical Purchasing Options and Improvements

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Questions Addressed by Study

THE NEW MEXICO LEGISLATURE HAS PASSED SEVERAL FOUNDATIONAL PHARMACEUTICAL PURCHASING AND MARKET REFORMS OVER THE PAST FEW YEARS.

WHAT ARE THE OPTIONS TO BUILD ON THAT FOUNDATION TO CONTINUE IMPROVING AFFORDABILITY, ACCESS, AND MARKET COMPETITIVENESS?

Overview of Findings

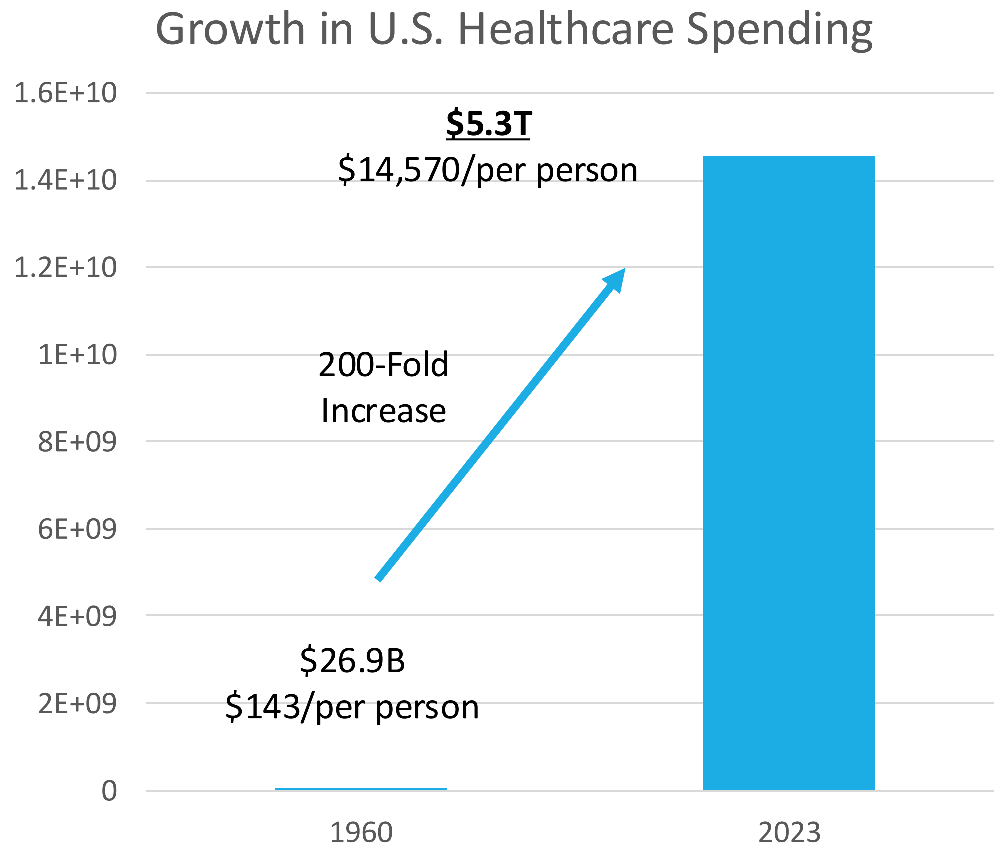
- New Mexico has established a strong foundation for pharmaceutical reform through recent legislative actions.
- The state's unique demographics create both challenges and opportunities for innovative solutions.
- Medicaid Rx utilization data (used as a proxy for statewide purchases) reveals significant concentration in high-volume, cost-effective medications, creating opportunities for strategic sourcing.
- Fragmented purchasing across programs may offer opportunities for additional savings through consolidation, improved negotiating leverage, and support for required infrastructure.
- Comparisons with leading states and other countries demonstrates proven models for substantial cost savings and improved outcomes.
- Multiple reform pathways are available, from targeted improvements to comprehensive system transformation.

The Evolution of Rx Use, Spending, and Distribution Underscores the Need for Broad Solutions to Improve Access, Affordability, and Outcomes

PHARMACEUTICALS HAVE BECOME A CRITICAL ELEMENT IN THE HEALTHCARE DELIVERY SYSTEM, SOLD AND DISTRIBUTED THROUGH DIVERSE CHANNELS AND SETTINGS.

DESPITE THAT TRANSFORMATION, RX PURCHASING AND MANAGEMENT ARE STILL PRIMARILY TREATED LIKE A SUPPLY PURCHASING ISSUE.

From Negligible to an Important Cost and Critical and Complex Therapeutic Alternative



1960

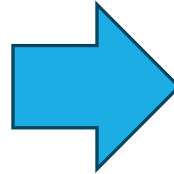
- Medications are 5% of healthcare spend
- Rx purchases primarily out-of-pocket ($101 per person annually)
- Primarily retail distribution
- Limited insurance coverage

Current

- Rx broadly insured, approaching 20% of total healthcare spending
- Complex, multi-channel sales and distribution
- 68% of adults take an average of 4 medications annually
- $3.5B annual costs for medication-related medical expenses
- Specialty drugs primarily drive expense growth, along with medicines delivered in non-retail settings

An Explosion of Pharmaceutical Innovation and Treatable Chronic Disease

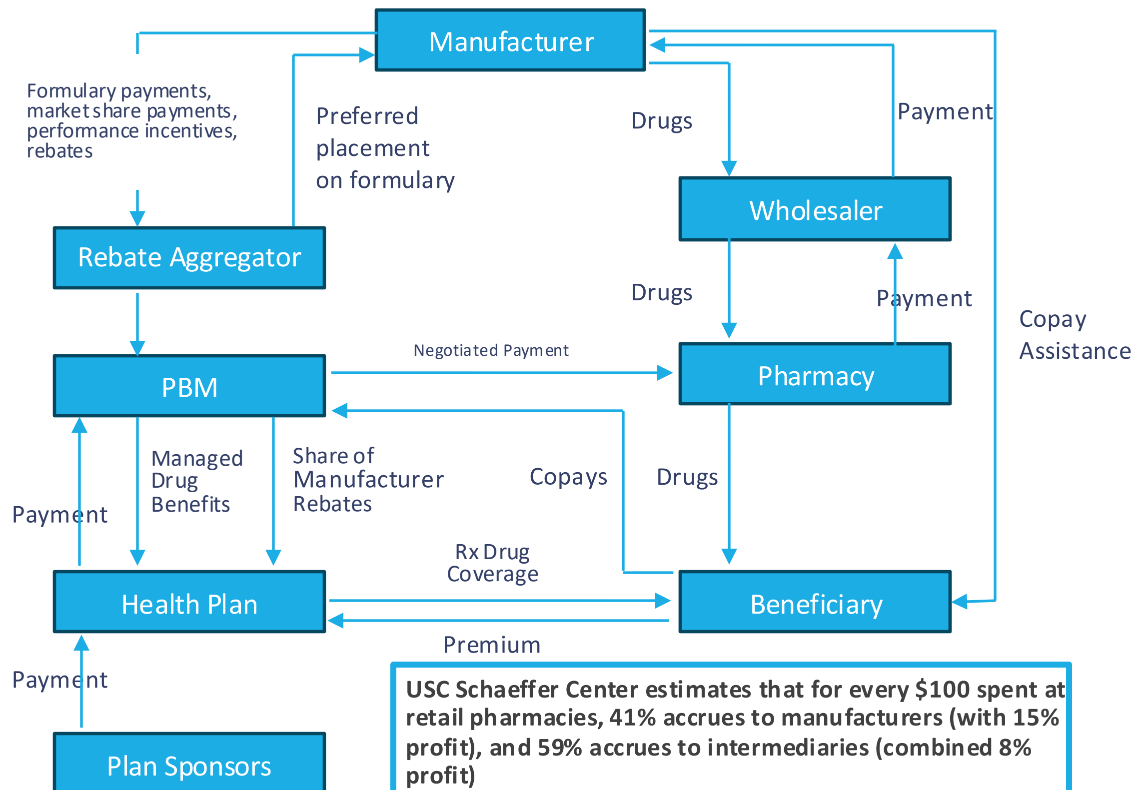
- Approximately 80-90% of drug utilization involves generic drugs.
- However, specialty drug costs account for 50-70% of total pharmacy spending and increased by 40% between 2023 and 2024. Yet, they are utilized by less than 2% of patients.
- $38,000/year in average costs for specialty patients, compared to $492 for non-specialty patients.
- Specialty drugs are primarily delivered outside traditional retail channels and are often bundled in other reimbursement.
- Compounded drugs are a separate category, projected to total $10B by 2033, with 130% growth since 2013.
- Traditional policy reforms often leave these areas largely untouched, focusing instead on retail and mail-order distribution channels.



- 51.8% of U.S. adults have at least one chronic condition, with 27% having multiple conditions, and obesity rates have more than doubled since 1980.
- Since 1960, there has been a 4-fold increase in the number of children with conditions that affect daily activities.
- Between 1980 and 2000, new drugs were developed for depression, cholesterol management, HIV/AIDS, Hepatitis C, and many other hard-to-treat illnesses.
- Since 2000, there has been significant growth in new, more highly specialized, and expensive specialty drugs, particularly in areas such as oncology and immunosuppression.
- The American Heart Association found that spending on 10 selected cardiometabolic drugs increased by 690% over ten years.

According to a recent analysis by Deloitte, the balance of healthcare spending has shifted from inpatient care, which has historically been the costliest sector, to prescription drugs. In fact, in some population segments, particularly commercial insurance, prescription drug spending has surpassed inpatient spending.

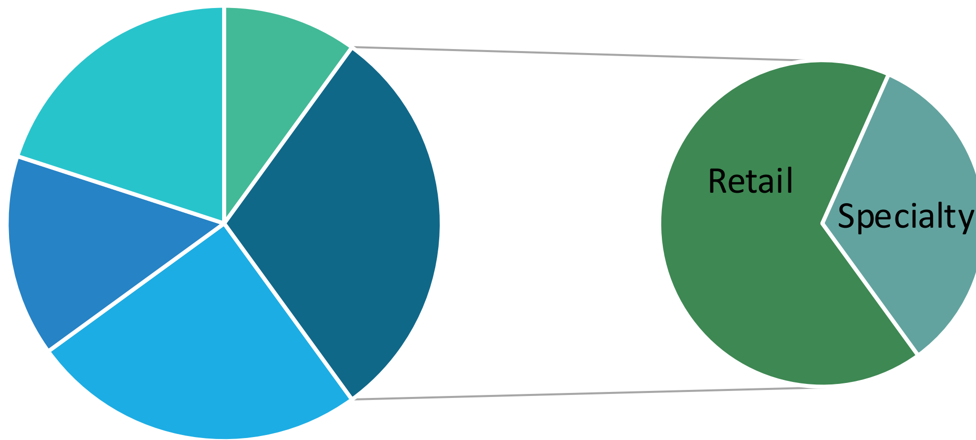
Emergence of New Rx Market Participants



Source: Adapted from USC Schaeffer Center Publication: The Flow of Money Through the Pharmaceutical Distribution System

- The emergence of these new pharmaceutical market participants has increased the need for profit-taking at each point in the value chain.
- Many of these separate business entities are owned by the same parent companies (e.g., MCOs owning PBMs, rebate aggregators, specialty clinics, pharmacies).
- Market participants will point out that this supports more efficient management of distribution and sales channels.
- However, bundling of these services may obscure **actual** costs through transfer pricing and cost allocation models.

Drugs Managed Differently Internationally: Rx as Delivery System Management



- 15 -20% pharmacy as a percent of total spend
- Management of Rx spending within global healthcare budgets
- Health Technology Assessment (HTA) to assess:
  - ✓ Benefits of the drug for health outcomes
  - ✓ Comparative value of drugs in a therapeutic class
- Prices negotiated, not set
- Initial price negotiations based on reference
- Separate negotiation with an initial grace period for new, branded products
- Generally open formularies with patient choice driven by OOP cost
- An expansive pharmacist's scope of practice and over-the-counter access
- Several states have adopted and built similar models through Medicaid transformation and global budgeting reforms

Broad Landscape of Reform In Small and Large States – Representative Examples

State	Reforms
Colorado	First state to implement upper payment limits on prescription drugs Prescription Drug Affordability Board with authority to set price caps Comprehensive transparency requirements
California	CalRx program for state-sponsored generic drug manufacturing $100M investment in biosimilar insulin production, with target price of $30/vial (one-tenth current brand prices) Comprehensive PBM regulation with 100% rebate pass-through
West Virginia	Carved out pharmacy benefits from Medicaid managed care Value-based pharmaceutical purchasing models $54.4M savings in first year, $122M retained in local pharmacies Eliminated spread pricing, implemented transparent fee-for-service model
Massachusetts	Comprehensive integrated pharmaceutical management with delivery system reform Value-based pharmaceutical purchasing models Achieved 2.3% annual pharmacy spending growth vs. 5.7% national average 60% increase in Hep-C treatment with 40% cost reduction per patient
Vermont	Transparency leadership as first state requiring manufacturer price increase justifications Comprehensive reporting and accountability framework 79% decline in drugs reaching price increase thresholds between 2016 to 2020

West Virginia:
- Insourcing
- MCO and PBM disintermediation

Massachusetts and Vermont:
- Similar to international models
- Built around delivery system transformation

Targeted State Reforms are Even More Broad Ranging

- **Purchasing Reforms:** Program consolidation, unbundling of purchasing and distribution, and reverse auctions.
- **PBM Business Practices:** Areas such as spread pricing, rebate transparency, patient steering, and 340b program fairness.
- **Pricing Reforms:** Including anti-price gouging, value-based purchasing, reference pricing, bundled pricing, and subscription pricing.
- **Purchasing Reforms:** Including multi-purchaser collaboration and negotiation, PBM alternatives, and direct-to-consumer alternatives.
- **Pharmacist Scope of Services Reform:** Including expanded prescribing, selected chronic illness management, medication and symptom monitoring, and testing.
- **Marketing Reforms:** Including gift bans and restrictions, sunshine laws, and university-based detailing programs (note: research indicates that marketing may add 10-20% to pharmaceutical costs.
- **Drug Discount Programs:** Including programs such as ArrayRx, and innovative and more expansive SPAPs (State Pharmaceutical Affordability Programs) targeting specific condition categories such as mental health (Pennsylvania).
- **340b Program Reforms:** Including non-discrimination requirements and expanded use in state programs.

New Mexico Has a Strong Starting Point for Additional Reforms

IMPLEMENTED PROGRAMS IN LICENSING AND REGULATION, COMPETITION, PRICING FAIRNESS, TRANSPARENCY, AND DATA REPORTING

WORK UNDERWAY ON STANDARD PDL

POPULATION CHARACTERISTICS SUPPORTING STRONG PHARMACEUTICAL PROGRAM TARGETING AND LINKAGE TO POPULATION HEALTH PRIORITIES

Potential for Significant Leverage Targeting Reforms for Key Groups

Benefit from improved market competitiveness, expanded access, transparency and discounts

- Private ERISA covered employees
- Medicare
- FEHBP
- Individuals and small groups
- Uninsured

Approximately 1.1 0 1.2M

+

Note: Numbers are Duplicative

Benefit from purchasing reforms

- 1.4 to 1.5 M under some form of state or local government health program
- Approximately 800K Medicaid beneficiaries
- 180K state government employees
- 80-90K local government employees

Highly fragmented with multiple procurements

New Mexico's Unique Rx Related Demographic Drivers

Geographic
- 30% of the population in rural counties have limited pharmacy access
- 32 of 33 counties designated as provider shortage areas
- Significant transportation barriers to accessing specialty pharmaceuticals

Economic
- 18.1% poverty rate (vs. 11.4% national average) increases affordability challenges
- High chronic disease burden requires ongoing medication management
- Limited health literacy affecting medication adherence

Diversity
- 50.2% Hispanic/Latino population with 2X diabetes prevalence
- 11.2% Native American population experiencing highest rates of diabetes, depression, and substance abuse
- 36.5% non-Hispanic white population aging rapidly with complex medication needs

Medication Utilization (Using Medicaid as proxy. May not include all specialty)

Extreme Volume Concentration

- The top 100 products (6.5% of all products) account for 82.7% of total units dispensed
- The top 18 products represent 80% of the total volume
- Indicates high standardization and opportunities for targeted negotiations

Cost-Volume Efficiency

- The top 100 products represent 82.7% of units but only 19.6% of total costs
- High-volume products are disproportionately cost-efficient
- The program demonstrates effective generic utilization

Strategic Implications

- 18 high-volume products offer maximum contract negotiation leverage
- 32 high-cost products require targeted utilization management
- Mental health represents the largest cost category
- Chronic disease management dominates utilization, supporting population health approaches

Leading Health Conditions by Impact (Using Medicaid as proxy. May not include all specialty)

Based on Total Cost	▪ Mental health/depression/anxiety: $128.6M (28 medications) ▪ Respiratory conditions: $42.9M (high cost per patient) ▪ Hypertension: $35.4M (excellent generic utilization) ▪ Diabetes: $20.5M (insulin vs. metformin differential) ▪ Pain management: $27.6M (mix of controlled and OTC)
Based on Prescription Volume	▪ Mental health/depression/anxiety: 1.2M prescriptions ▪ Hypertension: 537K prescriptions ▪ Bacterial infections: 382K prescriptions ▪ Respiratory conditions: 366K prescriptions

New Mexico’s Platform for Reform is Strong

Already Implemented Innovations

- Prescription Drug Transparency Board
- Drug price limits for insulin and behavioral health
- Drug Task Force and Stakeholder Engagement
- Early expansion of pharmacist scope of practice
- Established mobile and tele-pharmacy standards of practice
- Authorization and initial steps toward standardized PDL (Medicaid only)
- Some consolidated purchasing through IBAC and Interagency Pharmacy Purchasing Council
- Health Care Authority implementation with expanded oversight
- PBM licensing, oversight, and authorized practices
- Strong controlled substance and FWA oversight
- Initial 340b fairness requirements
- Specialty drug value-based reimbursement CMS approval

Gaps

- Procurement fragmentation
- In process (but not yet implemented) formulary (PDL) standardization
- Early-stage data and analytics capabilities
- Limited participation in collaboratives or cooperatives
- Separate drug procurement through MCO-provided PBMs for each
- Limited drug discount program and no SPAP

Implemented Reforms are Foundational, But Are Unlikely to Limit Continuing Cost Increases

WITHOUT CHANGES TO PROCUREMENT PRACTICES AND IMPLEMENTATION OF DRUG DISCOUNT SOLUTIONS, WE WOULD EXPECT A MINIMUM OF 7-8% ANNUAL DRUG COST INCREASES.

WE BELIEVE THERE ARE AT LEAST THE FOLLOWING REFORM PATHWAYS, WHICH ARE NOT MUTUALLY EXCLUSIVE AND CAN BE COMBINED TO MEET STATE REFORM GOALS

Three Potential Pathways Forward: Option 1 for Targeted Strategic Change

Targeted Strategic Improvements	▪ Join multi-state purchasing consortia (potential $1-5M annual savings) ▪ Complete common Medicaid PDL development and explore expansion to all state programs ▪ Complete analysis, develop a plan, select technology, and implement reverse auction ▪ Assess barriers to clinical pharmacist uptake, and develop reforms to increase use and expand the scope of practice to address access barriers, and increase MTM/polypharmacy management ▪ Develop SPAP (State Pharmaceutical Affordability Program) targeting low-income seniors and individuals with high-impact conditions (e.g., behavioral health) ▪ Develop and contract for new drug discount programs with alternative PBM partners ▪ Expand the 340b program and patient drug pricing protections ▪ Implement site-neutral specialty drug pricing ▪ Expand stakeholder engagement through the Drug Affordability Board ▪ Complete comprehensive pharmaceutical spend analysis to determine the need for additional reforms.
Timeline	▪ 1-3 years
Value	▪ Moderate Investment ($5-10M). Low Risk. Moderate Impact ($3-8M savings annually, ROI 300-800% within 24 months)

Three Potential Pathways Forward: Option 2 Comprehensive Procurement Reform

Procurement Reforms

- Consolidate all state pharmaceutical purchasing, with standard PDL (allowing some benefit differences where necessary)
- Evaluate insourcing and outsourcing options for health technology assessment services, select and implement
- Evaluate opportunities for collaborative, multi-state purchasing of high-impact drugs.
- Design distinct pricing models for generic, new branded, existing branded, specialty, and compounded drugs, incorporating reference pricing for high-value, therapeutically equivalent drugs, and value-based contracts for high-cost specialty drugs.
- Unbundle PBM and PBM-adjacent services from managed care contracts and procure separately (West Virginia, Oklahoma, Blue Shield California models)
- Expand procurement to qualified vendors and PBM alternatives within each service category.
- Implement reverse auction procurement for high-value generics.
- Strengthen Drug Affordability Board authority with upper payment limits.
- Enhance PBM oversight and audit recovery programs.

Timeline

- 2-4 years

Value

- High Investment ($20-30M). Moderate Risk. High Impact ($40-70M savings annually, ROI of 200-350% within 36 months)

Three Potential Pathways Forward: Option 3 Healthcare Delivery Transformation

Transformation Reforms	▪ Develop a delivery transformation proposal, taking advantage of the newly passed Rural Healthcare Transformation program (Vermont, Pennsylvania Models). ▪ Medicaid MCO disintermediation with waiver and State Plan Amendment development and approval ▪ Design and implement accountable care (ACO) and a global payment model. ▪ Integrate pharmaceutical policy and planning into state strategic health and population health planning. ▪ Develop and implement advanced data and analytics to support global pharmaceutical budgeting and outcomes-based contracts. ▪ Develop and implement an organizational model and infrastructure to support cross-program coordination and optimization.
Timeline	▪ 3-6 years
Value	▪ Very High Investment ($50-100M). High Risk. Very High Impact (20-30% trend reduction and additional savings of $100-150 M annually through comprehensive management, ROI 250-400% within 60 months)

Implementation Roadmap: The Next 18 Months

Phase	Initiative	Activities
Immediate Action (Months 1-6)	Stakeholder Coalition Formation	▪ Rural, tribal, consumer, provider, and industry engagement ▪ Establish shared vision and priorities
	Data Infrastructure Enhancement	▪ Expand APCD pharmaceutical analytics ▪ Baseline assessment of current utilization and costs
	Federal Coordination	▪ Begin discussions for Medicaid waivers and SPA if needed ▪ Multi-state collaboration exploration
Foundation Building (Months 7-12)	Governance Structure Refinement	▪ Strengthen cross-agency coordination ▪ Define success metrics and accountability
	Pilot Program Implementation	▪ Rural mobile and tele-pharmacy expansion ▪ Implement expanded 340b reforms ▪ Implement new drug discount program ▪ Pharmacist scope of practice expansion
Strategic Decision Point (Months 13-18)	Pathway Selection and Design	▪ Choose transformation scope based on stakeholder input ▪ Develop detailed implementation plan ▪ Secure necessary legislative and regulatory approvals

Stakeholder Engagement Strategy

Tier 1 – Essential Early Engagement	▪ New Mexico Hospital Association ▪ New Mexico Medical Society ▪ AARP New Mexico ▪ Major health plans operating in the state ▪ Tribal health organizations ▪ State Agency Leadership
Tier 2 - Coalition Building	▪ New Mexico Pharmacists Association ▪ Patient advocacy organizations ▪ Business and employer groups ▪ Rural healthcare providers ▪ Community health centers
Tier 3 – Implementation Partners	▪ Academic institutions and research organizations ▪ Professional associations ▪ Technology vendors and service providers ▪ Federal agency partners

Final Questions to be Addressed

WHAT LEVEL OF INVESTMENT IS THE STATE WILLING AND ABLE TO MAKE IN ADDITIONAL REFORMS?

HOW MUCH CHANGE IS THE STATE READY TO UNDERTAKE?

CAN REFORMS BE STRUCTURED TO MITIGATE RECENT FEDERAL CHANGES AND EXPLOIT NEW FUNDING IN AREAS SUCH AS RURAL HEALTH?