EXECUTIVE SUMMARY
New Mexico Needs a State Oversight Entity

We recommend the creation of a New Mexico Health Value and Access Commission that measures, monitors and reports on ways to improve the value of and access to health care in our state, and most importantly to ensure that our health system is sustainable. This Commission should be supported by an All Payer Claims Database (APCD) as are most similar entities in other states. The role of this oversight entity would be to assess cost drivers and quality/value measures across payment and delivery systems, identify problems, integrate health with social support systems and implement mitigating strategies. This will ensure that the best value is derived from the significant expenditures we allocate to health care in our state and that we develop innovative responses to inevitable future crises in funding.

Such a move is particularly urgent as costs in our health system continue to spiral upward.

According to CMS, "Projected National Health Expenditures (NHE) 2017-2026" will be as follows:[1]

- *Under current law, national health spending is projected to grow at an average rate of 5.5 percent per year for 2017-26 and to reach $5.7 trillion by 2026. While this projected average annual growth rate is more modest than that of 7.3 percent observed over the longer-term history prior to the recession (1990-2007), it is more rapid than has been experienced 2008-16 (4.2 percent).*
- *Health spending is projected to grow 1.0 percentage point faster than Gross Domestic Product (GDP) per year over the 2017-26 period; as a result, the health share of GDP is expected to rise from 17.9 percent in 2016 to 19.7 percent by 2026.*

These predictions pose a real threat to the sustainability of our health system. As a major entity with a stake in health care (both as purchaser and funding agent) the financial risks to the state from inaction will be significant.

As a purchaser of health care for its employees, the state regularly faces challenges funding health benefits and balancing those expenditures with its obligations to fund a statewide health coverage program like Medicaid. The Legislative Finance Committee in 2013, noted the following: ""Providing healthcare benefits for public employees has become a significant portion of the state's healthcare spending, second only to Medicaid. How the state manages its group benefit plans not only affects the state's fiscal health but also the amount of funding available for other high priority programs that serve New Mexico's children and families." [2]

Changes in policy at the federal level will add to the pressure on our state's coffers. CMS has signaled its intent to implement changes to Medicaid funding, to Medicare payment plans and to the Affordable Care Act's (ACA) health coverage for the general population. These changes could rattle major service delivery systems and providers in the state. Cost shifting would threaten the sustainability of our payer systems. And our state will inevitably be called in to help address both loss of coverage and potential losses in the service delivery system. Until now, our responses have been to shift costs to patients, cut or limit services and/or reduce provider payments. This is not sustainable. It could weaken our entire system, and should not be accepted as a given.

[1] CMS Office of the Actuary: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html

[2] Report of the Legislative Finance Committee Interagency Benefits Advisory Committee on Nov 22, 2013. See also follow up LFC Hearing Brief, Review of Group Health Benefits, August 25, 2016.

The only effective way to proactively ensure sustainability in our health system is to make certain that funds expended on health care act as an investment for maximum benefit in our communities, and to set up health and social service systems that work in harmony and with close coordination.

A stable health system is a solid, desirable economic driver for our communities, and healthy communities are important for the economic prosperity of New Mexico. Policy makers and business leaders should utilize outcomes to drive the cost dialogue to effect systemic changes in efficiency and process. We also need to recognize that social supports and care coordination have a critical role in delivering good health outcomes. At this time, there is no entity that can address these issues in a methodical and systematic manner.

So what prevents us from moving in this direction?

- There is no oversight entity with the mandate and access to comprehensive data across payers and providers
- We do not have the analytical capacity to collect, store and analyze these data (such as an all payer claims database), to model alternative options and recommend policy based on that information (i.e. data based solutions)
- We do not know the full, total expenditures on health care in our state nor understand the role of various cost drivers in each sector of our system well enough to manage these costs
- We cannot develop, recommend and implement systemic changes that will deter cost shifting, deliver value, eliminate waste and enhance the sustainability of our health sector.
- We do not know how to shape health care payment systems and costs to allow individuals to obtain the non-clinical services that are known to enhance health and wellness.
- We do not know how impending changes in Medicaid and Medicare will affect providers collectively
- State agencies responsible for services to the same population do not optimize coordination of services
- Policy leaders and business leaders are not emboldened to demand improved outcomes from the health systems they are financing, and to assert that measurable improvement in our population is a top priority

Five states have created state oversight entities[3]. Each of these entities have different scopes and were developed in response to different (local) financial pressures. Massachusetts lowered its cost growth to where they are no longer the highest per-capita costs in the country. Maryland's per capita healthcare costs were the lowest of six states in a recent study. Pennsylvania's approach has focused on hospitals, and it has measurably reduced waste in the hospital system engendered by inappropriate hospitalizations and hospital acquired infections. Each entity set different objectives and each demonstrated that aligning value and outcomes will (and can) curb the rate of cost growth in their states.

Finally, over 40% of the state's population lives in a primary care shortage area[4]. The population that remains uninsured and/or lives in underserved areas and the persistence of high health disparities adds a markedly different dimension of concern. With a Commission, we will have the opportunity to examine what could uniquely work for all of us. The proposed Commission will identify and prioritize innovative strategies to improve access to care regardless of income, age, race and/or ethnicity and where people live in this state. It will identify strategies that respond to the needs of our residents, and provide value for the tremendous investment made by public and private monies in health care for the residents in this state.

[3] Maryland (estb in 1974), Pennsylvania (1986), Vermont, Oregon (2009) and Massachusetts (2013).
[4] 2017 Health Data Summary https://hsc.unm.edu/research/ctsc/assets/doc/CERC/nm-health-data-summary.pdf