Status of LHHSC Contracts Addressing NM Solutions to the Systemic Causes of Rising HealthCare Costs

11/17/25

Healthcare costs are escalating at an alarming rate. The November election results demonstrated that we are all concerned about rising premiums and access to health care.

While the state provides funding to ensure the sustainability of health care services, out-of-control costs are making this increasingly difficult. Addressing the key drivers of rising health care costs is key to reducing costs and implementing systemic solutions.

Utilizing GRO funding from Reps. Liz Thomson and Eleanor Chavez, LFC, hired experts to develop solutions to key healthcare cost drivers. These included: Lowering drug prices, simplifying our complex payment and claims processing system, restructuring the Medicaid managed care program to reduce costs and protect access, *and* collecting the data required to ensure state-appropriate solutions.

The following is an update on the contracts and some recommended solutions.

1. Lowering RX Drug Costs

According to a November 5, 2025, Legislative Finance Committee report made to LHHSC,

> "New Mexico ranks 33rd when analyzing changes in the cost of prescriptions over the last 5 years." (p.22)

The report also points out that,

> "Medicaid pharmacy costs have increased by 67% between 2021 and 2024." (p.4)

Consultant: Dorothy Moller, a health care consultant for over 40 years, has developed options to help New Mexico lower escalating drug prices.

Report: In her June 15, 2025, report to LHHSC, she describes what states, both large and small, are doing, and the methods used by other countries with lower drug prices. Moller points out that Important NM legislation, such as expanding the scope of practice for pharmacists and drug price transparency, "*do not have the potential to impact cost and access significantly. That's where the next challenge lays." (p.4)* Systemic reform is required to address escalating prices.

Recommendations*: New Mexico could join a multi-state purchasing consortium or create its own drug purchasing board that would not have to rely on PBMs or controversial rebates. Reference pricing, using lower prices developed by other countries, is another tool.*

Decisions will need to be made about next steps.

2. Analyzing the impact of New Mexico's claims processing and billing system on clinicians and claims processors

This is a unique study as no other state has produced such specific information. It is essential to pursue additional New Mexico data to support the development of systemic solutions to address rising health care costs.

Consultant: Dr. Gabriel Sanchez of the UNM Center for Social Policy was contracted to analyze the impact of our complex claims processing and billing systems on health professionals and claims processors in New Mexico's rural and urban settings.

Report: The final report notes that each public and private insurance plan covers different drugs and procedures, with varying requirements *for justifying payment for services*. These requirements are constantly changing. This complex system frustrates both claims processors and clinicians, impacting morale and negatively affecting patient care.

Recommendations: Address the ever-changing rules and prior authorization restrictions that delay patient care and payment.

3. Simplifying our complex payment and accountability systems

Consultant: Dr Miriam Laugesen (Columbia University), a well-known expert on health services payment systems, will develop ways for New Mexico to address the costly and overly complex payment and accountability systems used by both public and private insurers, many of which are described in the Center for Social Policy analysis above.

Report: The research has three aims: (1) analyzing and collecting New Mexico data on how administrative arrangements impact New Mexico hospital and independent medical practice administrative costs; (2) describing state and international examples that offer simpler payment and accountability systems that lower costs; and, (3) recommending policy solutions that simplify payment and accountability systems, reduce costs and ensure access and quality of care.

Status: *A final report will be available in June 2026. Once alternative options are presented, decisions will have to be made about the next steps.*

4. New Mexico's Medicaid Managed Care Program

The NM Legislative Finance Committee's 2025 Medicaid Accountability Report shows that, despite a significant decline in enrollment, Medicaid expenditures continue to increase. Another concern raised was the availability of adequate data and information on utilization. Despite state investment and increased payments to the MCOs, outcomes are "worsening or the same." (pp. 1-2)

Consultant: Health policy expert, Dr. Michael Gusmano (Lehigh University), is analyzing the cost of New Mexico's Medicaid Managed Care Program.

Report: The purpose of this report is to "assess New Mexico's Medicaid managed care organization (MCO) approach through a critical policy lens to identify **structural inefficiencies** driving program costs. [emphasis added] The central question is whether Connecticut's 2012 transition from MCOs to a state-administered model offers viable lessons for New Mexico policymakers. Connecticut's experience represents a notable departure from the dominant MCO paradigm that deserves careful scrutiny.

Status: *The final report will be available in June 2026. Once alternative options are presented, decisions will have to be made about the next steps.*

5. Collecting New Mexico Health Expenditure Data

New Mexico does not have a health expenditure database to assess healthcare cost increases and to develop and determine the impact of various policy solutions on rising prices.

Consultants: A joint project of the UNM Business and Economic Research and the NMSU Arrowhead Center, these two state data experts worked on recommendations for creating a New Mexico Health Care Expenditure database to capture all health expenditures.

Recommendations: The final report noted that many states have created such a database, which is broader than an all-payer claims database. This database will have to be updated annually and will require a recurring appropriation.

Follow-up*:* $250,000 is required to set up the database, and approximately $ 200,000 is needed for yearly updates.

6. Future key systemic cost drivers worth considering

Aside from continued work on the selected issues and data collection, described above, other crucial systemic health cost drivers provide alternatives to the costly way health care is delivered in our state. These include:

• **Global Budgets** for hospitals and other health facilities. Maryland has successfully developed and implemented Global Budgets at the state level. The state received CMS funding for this work, and CMS stated that other states should pursue this approach. Global budgets provide a stable revenue system (especially for rural hospitals), reducing costs which can then be invested in a hospital's ability to provide better healthcare services.

• **Hospital resource sharing**. North Dakota, Minnesota, Montana, Nebraska, Ohio, and recently, Wisconsin have established networks to provide services they cannot afford individually.

•Develop a **secure inter-operational IT system**. Consultants would explore solutions that enable providers to access a patient's (confidential) history (such as tests, operations, inoculations, drug allergies, etc.), allowing all clinicians to access this critical information.

7. Budget requests

Projected cost drivers budget: $1 million for this year's budget. (Future annual appropriations will be required depending on the solutions and how much work they entail.). This money will be used to continue research **for solution-focused implementation** that addresses the systemic drivers of rising health care costs. This investment includes hiring consultants, economists, legal experts, a cost driver project coordinator, a grant writer, and other required resources.

Projected budget for the state expenditure database. According to Arrowhead and BBER, $250,000 would cover the cost of putting together the health expenditure database. An appropriation of $200,000 would be required for annual updates.