Improving Access to Care in New Mexico

NMMS ADVOCACY FOR THE 2025 LEGISLATIVE SESSION

New Mexico Medical Society

Since 1886, the New Mexico Medical Society (NMMS) has been dedicated to the advancement of medical science to serve our state's health care needs.

Through the elevation of the standards of medical education, the enactment and enforcement of just medical laws, and the promotion of medical ethics as set forth by the American Medical Association, we seek to keep members of the medical profession at the forefront of medical practices.

From our annual medical conference to ongoing continuing education, from physician advocacy before the New Mexico Legislature to the United States Congress, we work to improve health care and the physicians who provide patient care and ancillary services.

For health care consumers in New Mexico, we serve to promote the physicians that uphold these important tenets and work to educate and advocate about public health issues that affect our state.

New Mexico Medical Society

Not-for-profit association representing close to 2,400 MDs and DOs, including residents in training and medical students at UNM-SOM and Burrell College of Osteopathic Medicine. We represent all specialties, all practice types (self and organization employed), all stages of the career from student to retired.

Focus on advocacy, education, and problem solving.

Last few years renewed emphasis on relationship with residents and students. Have a family medicine resident "policy" intern in Santa Fe and a rotation available for current medical students.

Relationships with national and state healthcare association (e.g. AMA, NMHA, Medical Board, GACC).

Goal is to create a practice environment that invites physicians to stay in and move to New Mexico.

1. Stabilize Current Medical Infrastructure
2. Support Clinicians and Expand Services
3. Build our Future Clinician Pipeline

Unique Challenges New Mexico Must Overcome

According to a 2022 report released by the Association of American Medical Colleges, the U.S. faces a projected shortage of between 37,800 and 124,000 physicians by 2034.

- AAMC projects by 2034 include shortages of 17,800 – 48,000 primary care physicians and 21,000 – 77,100 non-primary care physicians.

New Mexico is competing against every other state in the union to attract and retain physicians– and solving our shortage issues will be even more challenging due to social struggles we are working to overcome and the extremely rural nature of our state.

New Mexico's shortage is severe – Workforce Solutions reports that as of April 2024 there were **2,200** posted openings for physicians.

Physicians Advocacy Institute – "Physician Employment Trends in the US and New Mexico"

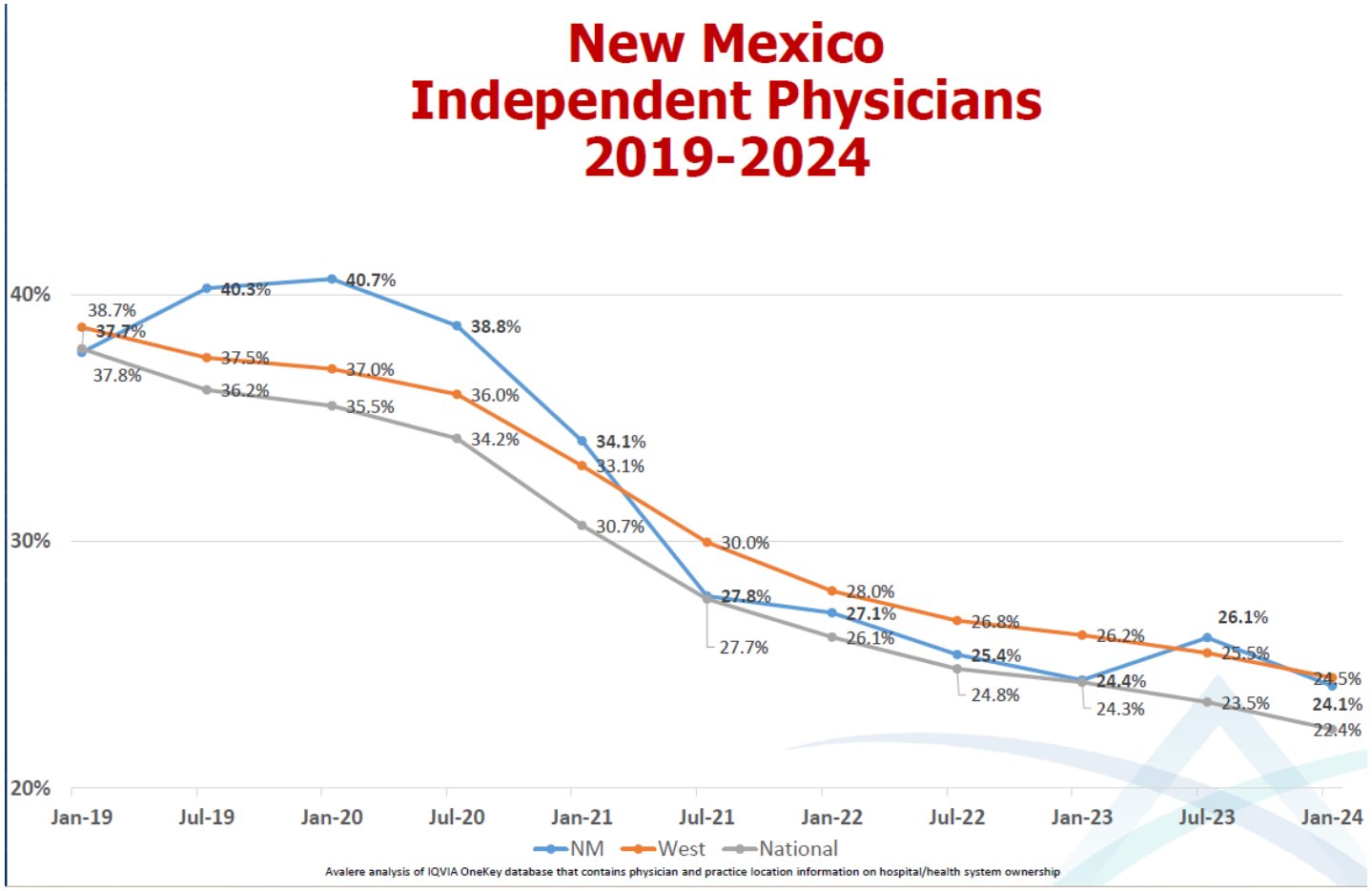
New Mexico was the only state in the country experiencing a trend in 2018-2020 where more physicians were transitioning to independent practice.

This trend reversed at the end of 2021 with New Mexico now close to the national average for percentage of physicians employed by a hospital, health system, or corporate entity.

As of January 2024, only 25% of New Mexico's physicians are in independent practice.

What happened in 2021 to reverse the trend of physicians becoming independent?

What are the challenges to successful independent practice and what can policymakers do to solve these challenges?



New Mexico Trends- Key Employment Transitions (Cont.)

	Total 2019 Practicing Physicians	Total 2024 Practicing Physicians	Difference Between 2019-2024
New Mexico	3,039	2,791	**-248**
National	603,726	647,998	**44,272**

Every data point shows New Mexico has **lost** physicians in the last five years. This data was collected using billing information to examine how many physicians are actively billing for patients in every state.

New Mexico was the only state in the country that experienced a loss of physicians from 2019-2024.

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Healthcare Issues All Impact Each Other: Stop Discussing them in Silos

Medicare helps tell the story of low reimbursement rates

Physicians have experienced no notable increase in Medicare in 20 years – **2025 actually cut physician reimbursements by 2.8%**

New Mexico Medicare reimbursement rates are **lower** than our surrounding states due to the Geographic Practice Cost Index (GPCI)

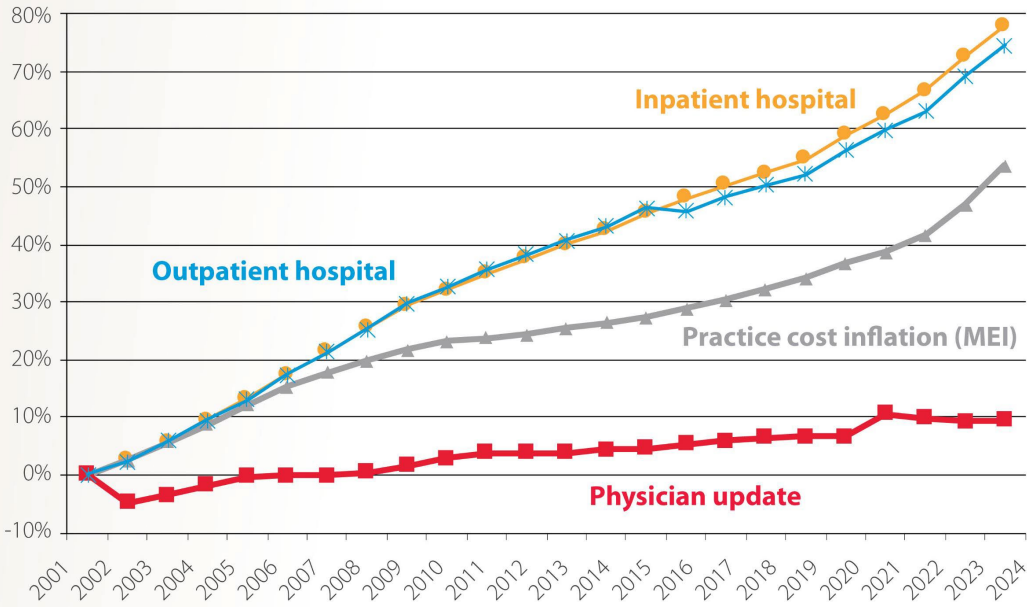
Federal action on Medicare has a **much larger** impact on New Mexico's physicians than other states due to our reliance on the system for direct patient care and reimbursement rates for all other services.

Medicare physician payment is NOT keeping up with practice cost inflation.

Medicare updates compared to inflation in practice costs (2001–2024)

Adjusted for inflation in practice costs, Medicare physician payment **declined 29%** from 2001 to 2024.

AMA AMERICAN MEDICAL ASSOCIATION



Sources: Federal Register, Medicare Trustees' Reports, Bureau of Labor Statistics, Congressional Budget Office.
Note: Updates from the Consolidated Appropriations Act of 2024 have been incorporated.

Updated May 2024

We need to fix Medicare physician payment NOW.

Medical Practices are Unique Businesses

Why is it so hard to run a medical practice?

- Because medicine is the **only** industry in which the business cannot control the price of the services or goods we provide.

Medicare reimbursement rates continue to decline– in New Mexico, approximately 70%+ of patients are covered by government insurance (Medicaid or Medicare) so any changes in these reimbursement rates have an outsized impact.

The rates practices receive for procedures are set through a lopsided negotiation process with an MCO where the practitioners almost always receive less payment for the procedure than the cost to provide it.

- The rates for commercial plans often fall back on Medicaid and Medicare rates, which we show are lower than practice costs.

These rates are set, often, more than a year in advance of the service provided through the fee schedule. Some of the contracts have evergreen clauses that make it difficult for providers to renegotiate rates for years at a time.

- This means “new price setting” cannot occur mid-year to react to growing costs.

The only way to increase revenue is to see more patients, which is not the best quality of care, or to accept only private pay patients in which the provider can set their own prices. But most New Mexicans could never afford to receive care in that setting.

No Margin, No Mission

Even with the best of intentions to provide excellent healthcare to those in need, without the ability to adequately pay practitioners and support staff, the mission will fail.

Other professionals are paid for their expertise. In medicine, much of the payment is linked to quality of the result. For many of these outcomes, we as practitioners have only mild to moderate control.

- Patients assigned to our panels choose not to participate in quality recommendations. Refuse vaccines, miss specialty care appointments, no-show for lab follow ups, refuse nutrition consults, go to the ER for mild illness without calling us first, etc.

Insurance companies cut codes or deny, state patient responsibility, cut code payments or bundle fees (example G2211)

- **HCPCS code G2211** was created to recognize the additional resource costs associated with providing care for a single or multiple complex or serious conditions. Many insurance companies are not paying this code

Practitioners are PAID not REIMBURSED (payment is the exchange of money, goods, or services for something else while reimbursement is the repayment of money already spent)

Independent practices are major employers in their communities

A PRACTICE NEEDS MORE THAN JUST PHYSICIANS TO BE SUCCESSFUL.

Major costs of independent practice are not recognized in payment structures.

BUT THE CARE WE PROVIDE IS MORE COST EFFICIENT THAN HOSPITAL CARE.

Costs Required to Serve Patients

Medical malpractice: $557,182/ year; SWGA- $411,973 (for 2024) SWE- $145,209

Electronic Health Records: $900,000 per year

Phone and night triage are not paid

Prior Authorizations: ~105/day, or ~26,460/year; we outsource a portion this, but at a collective cost of 10FTE

Continuous monitoring of insurance payments, staff and practitioners spend time emailing/ phone requesting proper payments

- Prior auth “appeals”/ peer to peer reviews require practitioner to call, set up specific appointment (often 4-5 days later), usually review is not with a true “peer” (can be pharmacist or clinician that is trained in another specialty)
- Payments withheld for months for “review “ purposes
- GRT repayment held for over 9 months
- Threats of OSI reporting, personal call to MCO or contract termination sometimes the only way to have insurance act on an issue

MCO negotiations – we cannot serve patients if MCO’s refuse to negotiate in good faith (especially the Medicaid MCOs)

Independent Practice vs. Health Systems

Physician services delivered within health systems cost between 12% and 26% more compared with independent practices. System based hospital services cost 31% more, on average, compared with care delivered by independent hospitals.

Independent practice provides high quality care at a margin of the price of large hospital systems.

We should proactively make decisions to support independent practice.

MORE INDEPENDENT PRACTICE IMPROVES QUALITY IN THE SYSTEM OVERALL

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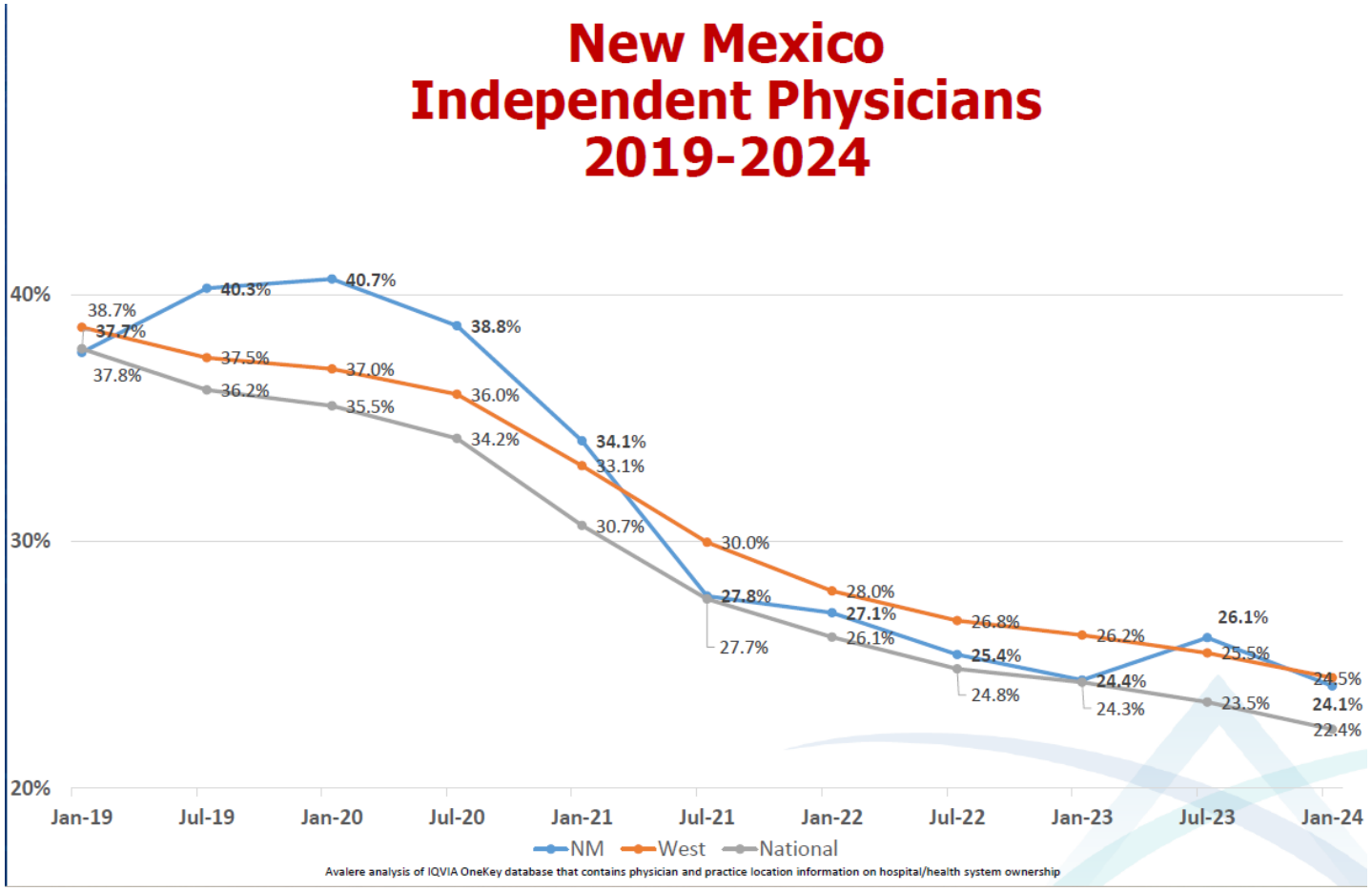

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Why is Medicaid so Important?

Medicaid revenue is the cornerstone of most practices in New Mexico. Stabilizing this revenue stream to cover costs, and provide a cushion for reinvestment in practices, is critical to the business of medicine.

Medicaid

- Currently covers 43% of New Mexicans and 60% of all New Mexico's children
- Medicaid is the biggest payer in the NM healthcare system
- With every state dollar spent the federal government reimburses $3.45

The overall goal is to provide access to the care that is needed. Increasing Medicaid payments is the most direct way to reach that goal. Without the revenue the workforce, supplies, and up-to-date technology will not be available.

Better revenue allows practices to:

- Spend more time with patients.
- Offer more competitive pay.
- Modernize practice tools.
- Provide ongoing training opportunities.
- Reinvest in delivering health care.
- Develop recruitment packages and retention bonuses.
- Hire critical patient care team staff and administrative support staff.

Medicaid Funding

The FY2024 budget is to be commended for the significant investment it made in Medicaid– but more must be done to stabilize and grow Medicaid reimbursements in future fiscal years.

- New professional services fee-for-service reimbursement rates are 120% of Medicare for Primary Care, Maternal & Child Health, and Behavioral Health.

The FY2025 budget raised Medicaid reimbursement rates for physicians again to 150% of Medicare for Primary Care, Maternal and Child health, and Behavioral Health starting January 1, 2025.

- All other professional services fee-for-service reimbursement rates are 100% of Medicare.

Continue to prioritize Medicaid funding in the budget so there may be increases in the fee-for-service schedule for all clinicians, both primary care and specialists. The HDAA from 2024 was monumental in stabilizing revenue for hospitals, but did not increase Medicaid rates for independent practice physicians. The fee-for-service schedule and facility fees require continued investments from the Legislature.

Create a Permanent Trust Fund for Medicaid

AS MEDICAID IS A LARGER PORTION OF THE STATE'S BUDGET AND FUNDS MORE PROGRAMMING FOR NEW MEXICANS, WE MUST INSULATE IT FROM THE EBBS AND FLOWS OF THE BUDGET

Prior Authorization

Gold Cards currently exist but those gold cards are for single procedures or single drugs

Legislation would expand gold carding as follows:

- If for the last two years a provider had a 90% approval rating, post appeal, for their prior authorizations, the provider could apply and be approved to receive a gold card for all procedures and advanced imaging within their scope/specialty for the next 5 years.
- Gold cards non-transferrable within a practice – tied to the individual clinician
- Insurers would be permitted to perform audits to ensure providers did not abuse gold card privileges

Legislation would apply to commercial and Medicaid insurers

Economic Credentialing

16 states + District of Columbia have statutes that prohibit economic credentialing

economic credentialing is defined as the use of **economic** criteria unrelated to quality of care or professional competency in determining an individual's qualifications for initial or continuing hospital medical staff membership or privileges

There are current examples of hospitals denying credentials to NMMS members based on economic criteria

Intent of the legislation is to ensure that when physicians meet the criteria to be credentialed, as established by hospital bylaws, the hospital would be required to credential

Healthcare and Economic Development

Currently, healthcare is **not** a qualifying entity for Local Economic Development Act (LEDA) dollars because healthcare was not viewed as economic development strategy under previous administrations.

NMMS believes healthcare is not only necessary for economic diversification in New Mexico, but healthcare in it of itself is an economic development strategy.

By including **independent** healthcare entities in as a qualifying entity for LEDA, the state would open up local investment resources for capital resources clinicians need to open practices and facilities.

Other Important Considerations

Continued funding for Health Care Professional Loan Repayment so awards can meet demand.

Increase funding for resident salaries so New Mexico can recruit the best and brightest future physicians – also remember that we must create a practice environment that makes these residents **want** to stay here.

Medical Malpractice Cost Containment Measures – focus on the definition of occurrence so it mirrors the original legislative intent, punitive damages, fund premium support efforts requested by the Superintendent of Insurance.

More Considerations

Mergers and Acquisitions – balance the need for governmental oversight in the consolidation of healthcare without creating barriers for working capital, investments and growth in health care.

Protect clinician autonomy to make clinical decisions.

Consider “public capital and operational support” opportunities for lending through NMFA, Rural Healthcare Delivery Fund, LEDA, etc.

Health Information Exchange – consider state grants to assist practices in “hooking up” to the HIE so patient records can be shared more efficiently.

Gross Receipts Taxes – professional service contracts, medical services, Medicaid payments

Integrate Medical Trainees in Community

Public Education – state agencies should coordinate career and technical education (CTE) funding to prioritize programs aligned with state workforce shortages

- Require high schools receiving state CTE dollars to have health care components – APN programs, registered nurses, EMT, Pre-Med, etc.

Provide tax incentives to health care clinicians or their practice when they:

- Create a paid internship for a high school student (e.g. summer job);
- Create a paid internship for a college student – rural health medicine internships with our community providers;
- Become a preceptor for a health care student in training (medical students, nurses, behavioral health, residents , etc.).

Encourage local practices and rural hospitals to train medical students, Residents, and APRNs through Medicaid differential.

- Independent practices in Oklahoma take medical students from Oklahoma State University in exchange for an enhanced Medicaid rate.
- Oklahoma uses a tiered approach and offer 5% to 20% above the base Medicaid rate based on the number of students the practice agrees to train.

Questions?

ANGELINA VILLAS ADAMS, MD, SOUTHWEST GASTROENTEROLOGY, NMMS PRESIDENT

CARIE ROBIN BRUNDER, LOBBYIST, NMMS