

NMMS Noon Zoom

NMMS ADVOCACY
FOR THE 2025
LEGISLATIVE SESSION

NM Legislative Session

2025 Legislative Session is a 60-day Session

- All issues may be discussed
- January 21 – March 22

Legislative Leadership

House of Representatives

- Speaker Javier Martinez
- Majority Leader Reena Szczepanski
- Majority Whip Dayan Hochman Vigil
- Minority Leader Gail Armstrong
- Minority Whip Alan Martinez

Senate

- President Pro Tempore Mimi Stewart
- Majority Leader Peter Wirth
- Majority Whip Michael Padilla
- Minority Leader Bill Sharer
- Minority Whip Pat Woods

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.

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.

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.

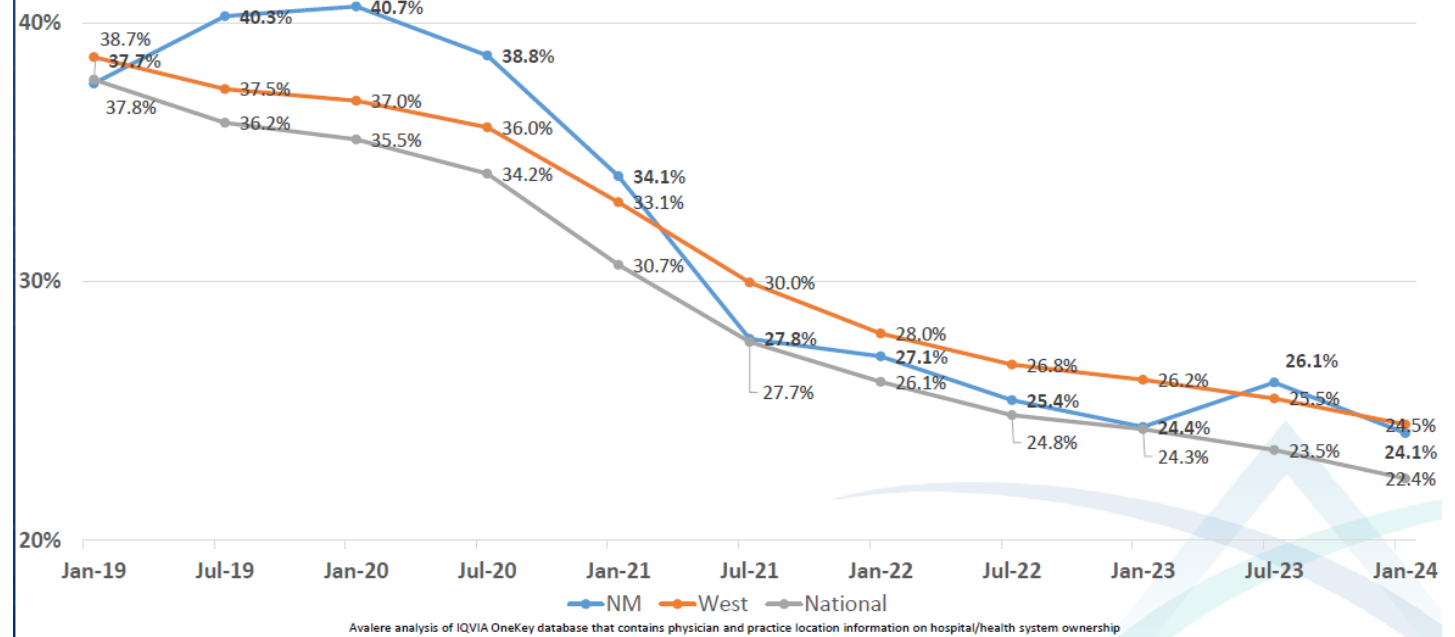
This trend reversed at the end of 2021 with New Mexico now close to the national average for percentage of physicians employed by a hospital, health system, or corporate entity.

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 Independent Physicians 2019-2024




New Mexico and National Findings + or – Clinically Practicing and Billing Physicians

	Total 2019 Practicing Physicians	Total 2024 Practicing Physicians	Difference Between 2019-2024	Percentage gain/loss 2019-2024
New Mexico	3,039	2,791	-248	-8.1%
National	603,726	647,998	44,272	7.3%

New Mexico Compared To Neighboring States

+ or – Clinically Practicing and Billing Physicians

	Total 2019 Practicing Physicians	Total 2024 Practicing Physicians	Difference Between 2019-2024	Percentage gain/loss 2019-2024
Oklahoma	6,057	6,321	264	4.4%
Texas	42,479	48,775	6,296	14.8%
West	131,864	141,761	9,897	7.5%
Arizona	11,283	12,981	1,698	15.0%
California	67,011	72,303	5,292	7.9%
Colorado	10,842	11,427	585	5.4%
Nevada	4,641	4,667	26	0.6%
New Mexico	3,039	2,791	-248	-8.1%
National	603,726	647,998	44,272	7.3%



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

FY2026 Budget

Budget Projections

- Estimated recurring revenues for FY25 are \$13.26 billion, up \$247.3 million from the last estimate in August 2024 and, are 1.6 percent more than generated in FY24.
- Although growth in revenue has slowed, the amount available for appropriation remains high due to fiscal restraint in recurring appropriations and higher base revenues. In FY26, recurring revenues are expected to grow only 2.6 percent over FY25 to an estimated \$13.61 billion.
- While recurring revenue is \$3.4 billion more than prior year recurring spending, nonrecurring spending has grown rapidly in recent years and now represents more than 27 percent of spending in a single session and potentially a third of spending in a single year.
- **Total revenues less total prior year spending more accurately reflects new general funds available over prior years, which is \$892.3 million in FY26.**

Superintendent of Insurance

\$25 Million request for medical professional liability insurance premium reduction

No requests for PCF shortfall because unnecessary.

P797 Patient's Compensation Fund

Explanatory	Number of claims reported to the patient compensation fund	NEW	N/A	N/A
Explanatory	Number of participating providers enrolled into the patients' compensation fund	NEW	N/A	N/A
Explanatory	Total amount of settlements reached (i.e. claims paid)	NEW	N/A	N/A
Explanatory	Patients' compensation fund actuarial deficit, in millions	(17.0)	N/A	N/A
Efficiency	Percent of required reports submitted timely to the national practitioner data bank	98%	Discontinued	Discontinued
Efficiency	Percent of required reports submitted timely to the centers for medicare and medicaid services	100%	Discontinued	Discontinued
Explanatory	Audit of all uploaded transactions within twenty four hours	100.0	N/A	N/A

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%**

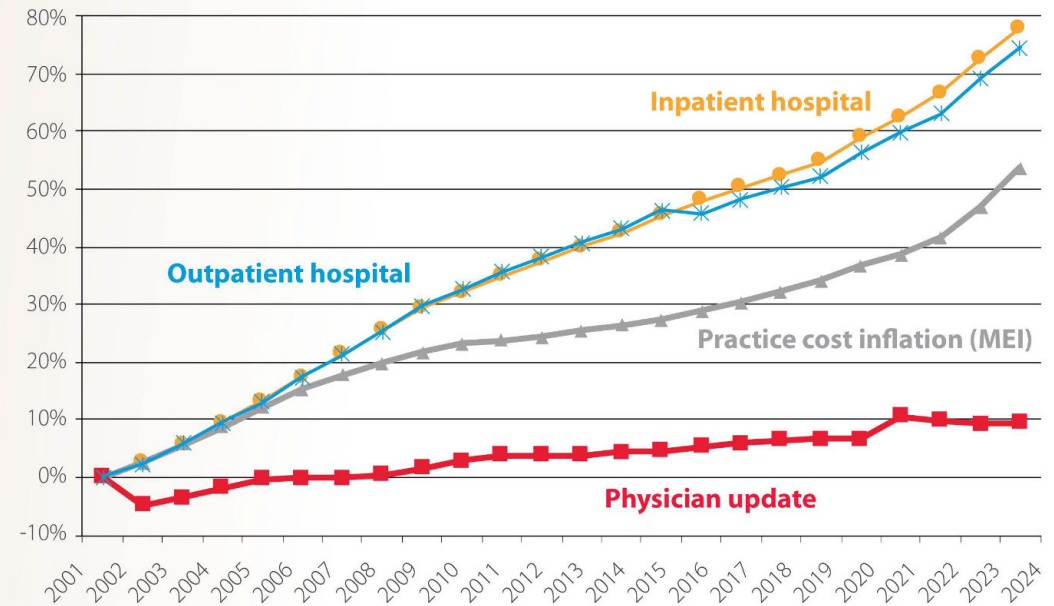
New Mexico Medicare reimbursement rates are **lower** than our surrounding states due to the Geographic Practice Cost Index (GPCI)

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.



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.

FY26 HCA GF BASE BUDGET REQUEST BY DIVISION

Division	FY26 GF Request (\$000s)	FY26 FF Request (\$000s)	FY26 Total Request (\$000s)	% GF Increase FY25-26	Primary FY26 Request Cost Drivers
Income Support Admin (P525)	\$60,180.8	\$113,657.3	\$173,838.1	37.5%	Continue 8% salary retention incentive for caseworkers beyond SNAP settlement; customer contact center supports; sustain funding for 158 existing FTE.
Developmental Disabilities Supports Division (P519)	\$294,029.2	\$19,008.3	\$313,037.5	16.4%	Increased number of individuals receiving waiver services, reduction in FMAP, maintain no waitlist
Medical Assistance Division Admin(P052)	\$34,172.1	\$141,498.9	\$175,671.0	12.0%	Increase in contract costs, primarily related to MMISR go-live. Funding for existing FTE to support new programs and MCO oversight.
Medical Assistance Division Program (P976)	\$1,678,375.8	\$10,773,476.6	\$12,451,285.2	11.0%	Increase in provider rates for a full year. Reduction in federal match. 1% enrollment growth. 2.6% projected medical cost growth. Lower revenues (Drug Rebates, CSMF, Tobacco Settlement, Opioid).
Behavioral Health Services Program (P767)	\$49,042.0	\$26,411.6	\$75,453.6	5.4%	Replace nonrecurring opioid settlement revenue with GF.
Information Technology Division (P522)	\$28,504.6	\$56,703.8	\$85,208.4	3.0%	Increased costs related to licenses and contracts.
Child Support Services (P523)	\$13,355.4	\$27,067.2	\$40,623.6	3.0%	Replace nonrecurring federal revenue with GF.
Program Support (excluding IT) (P522)	\$7,967.0	\$19,777.7	\$27,744.6	3.0%	Increased costs related to contracts and office space.
Division of Health Improvement (P520)	\$11,714.0	\$10,579.0	\$22,293.0	1.7%	Request to replace 20-year-old database supporting intake and investigations of abuse, neglect, and exploitation cases. Upgrade will provide stability of client and investigation data documents along with analytics to facilitate prevention.

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 six months 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
- 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.

Scope of Practice

Chiropractors as Primary Care

Optometrists

Physician Assistants

Pharmacists

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.

Physician White Coat Day: January 29

Questions?

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