NORC at the University of Chicago

FINAL REPORT

November 2023

An analysis of methods to reduce administrative costs in the health care system in New Mexico

Presented by:
Megan Stead
Stead-megan@norc.org

Elizabeth McOsker
Mcosker-elizabeth@norc.org

NORC at the University of Chicago
55 East Monroe Street
30th Floor
Chicago, IL 60603

Presented to:
Legislative Council Service
490 Old Santa Fe Trail, Suite 411
Santa Fe, New Mexico 87501
505-986-4600

Contributors

This report reflects the contributions of the entire project team, including the following individuals:

Elizabeth McOsker, NORC, project lead
Megan Stead, NORC, project director
Beth Landon, independent consultant
Rebecca Catterson, NORC
Caty DeBroux, NORC
Millie Dibble, NORC
Alex Hartzman, NORC
Scott Leitz, NORC
Tina Nye, NORC
Elizabeth Rovegno, NORC
Abby Wolk, NORC

And the 19 key informants who graciously donated their time to be interviewed for this report

Table of Contents

List of Exhibits

Executive Summary

The New Mexico Legislative Council Service, acting on behalf of the New Mexico Interim Legislative Health and Human Services Committee (LHHS), funded NORC at the University of Chicago to "conduct an analysis of methods to reduce administrative costs in the health care system in New Mexico, which shall: identify, describe and analyze methods to reduce the administrative costs in the health care system and provide recommendations for health care administrative cost reduction" and subsequently "discuss the possible pros and cons of the methods identified." This report presents the results of this analysis.

NORC gathered and analyzed information from a variety of sources to develop recommendations for reducing administrative health care costs in New Mexico. First, we conducted a literature review to identify expert recommendations and strategies that have been evaluated for cost-effectiveness.[1] Based on discussions with our New Mexico consultant, Beth Landon, NORC selected strategies to discuss in key informant interviews. We then conducted those interviews with 19 expert stakeholders in New Mexico, including government officials, payers, providers, and consumers of health care.[2] During interviews, we asked stakeholders to note their "top of mind" administrative cost reduction strategy, or their greatest area of concern related to administrative costs. NORC also conducted an analysis of hospital cost reports, IRS Form-990s, and other administrative files (e.g., fee schedules) to understand the financial context and overall administrative burden of New Mexico health care facilities. Finally, NORC synthesized findings and developed themes from across the literature review, interviews, "top of mind" strategies put forth by stakeholders, and analytic review to develop 11 recommendations for the LHHS to consider in seeking to reduce administrative health care costs.[3]

In this report, we have grouped our recommendations by potential legislative action. We recommend:

- A series of short-term legislative policy options to enhance uniformity and consistency across payers,
- A short-to-medium-term commissioning of a special report or development of a legislative committee to review and suggest reforms regarding medical malpractice in New Mexico, and
- The longer-term formation of a committee to develop a strategic plan to implement a healthy strategy and impact council.

Develop Legislative Packages to Enhance Uniformity and Consistency Across Payers

Findings support continuation of New Mexico's ongoing efforts to enhance uniformity and consistency between payers and providers. The most frequent areas identified, via literature review and interviews,

[1] Please see Appendix E for our literature review protocol. Additionally, Appendix D lays out all the strategies found in the literature review, including those we did not recommend or further examine.

[2] Please see Appendix F for the interview protocol and Appendix G for a list of interviewees.

[3] Please see Appendix B for a full review of study methodology.

to promote uniformity and consistency include claims and billing, prior and continuing authorizations, standardization of payer contracts and quality reporting measures, and common portals. Specifically, NORC recommends:

1. **Standardize and reform prior authorization practices,** including:
   a. Standardizing the list of services that require prior authorization across payers
   b. Encouraging plans to selectively use prior authorization
   c. Using a standardized electronic interface for prior authorization
2. **Develop and implement an administrative simplification package to standardize billing forms and claims submission across payers.**
3. **Align state and payer quality metrics with federal ones**, including appropriately limiting use of additional metrics by payers.
4. **Require appropriate standardization of organizational contracts** to advance compliance with policies of interest, including administrative simplification, standardization and reform of prior authorization, alignment of quality metrics, and submission of data to the state all-payer claims database (APCD) and health information exchange (HIE).

Commission a Special Report or Legislative Committee to Recommend Medical Malpractice Reforms

Findings support the Legislature investing in a special study to fully document the implications of House Bill 75 of Findings support the legislature's investing in a special study to fully document the implications of House Bill 75 of the 2021 Regular Session of the New Mexico Legislature entitled "Clarifying and Modernizing the Medical Malpractice Act (HB 75)." In NORC's interviews, nearly all stakeholders articulated concerns about the current and future financial impact of this legislation on New Mexico's health care system. At this time, approximately three companies across the country are willing to provide insurance for New Mexico's hospitals, and they have reportedly increased their rates consistent with the losses and instability of the market. The practice of venue shopping[4] and current definition of an occurrence, or event, further exacerbate the likelihood of lawsuits, leading to concerns about hospitals' ability to afford malpractice insurance and attract an adequate workforce. Our specific recommendations and potential considerations include:

1. **Conduct a further unbiased and comprehensive study of the impacts of the state's medical malpractice requirements on hospital budgets and the health care workforce.**
2. **In the interim, consider several actions relative to House Bill 75**, including:
   a. Synonymously define:

[4] Venue shopping occurs when a lawyer carefully picks a court in which to file their case where the chances of a judge ruling favorably are strong (Foley Law Offices 2015).

   i. "Malpractice claim" and "occurrence" so that a single injury event is recognized and treated as a single claim or occurrence
   ii. "Medical care and related benefits" to be only costs paid by or on behalf of the injured patient and not tied to billed charges

b. Prohibit "venue shopping" and obligate a case to be heard in the county where the health care provider is located, or where the patient resides, unless there are well-defined and limited criteria for a change in venue.

Develop a Strategic Plan for Implementing a Health Strategy and Impact Council

Our findings support the creation of a health strategy and impact council, to be housed within the new Health Care Authority, to enact further administrative cost reductions, utilizing New Mexico's investments in a digital health care infrastructure, especially the APCD, the HIE, and the updated Medicaid Management Information System (MMIS). States that have seen the most successes in bending the health care cost curve share a commonality—they all have some sort of health policy commission to analyze data, recommend actions, and evaluate progress toward cost-saving goals. A commission of experts, with access to up-to-date and accurate data, can function with, but operate separately from, state departments and the legislature, allowing for independent recommendations and evidence-based decision-making. Specific recommendations include:

1. **Fund and develop a health strategy and impact council to provide oversight and monitoring of New Mexico's digital infrastructure and cost containment efforts:**
   a. House the council within the Health Care Authority.
   b. Develop and fund the entity based on best practices in considering governance and staffing, policy scope and accountability measures, data access, funding and resources, and stakeholder engagement.
2. **Through the health strategy and impact council, monitor trends in health care spending,** including reviewing federal funding opportunities and evaluating proposed changes in ownership or affiliation.
3. **Through the health strategy and impact council, consider implementing growth caps to mitigate health care cost drivers,** including appropriate enforcement mechanisms.
4. **Ensure that the health strategy and impact council has access to state-administered databases (i.e., MMIS-Replacement, HIE, and APCD)** for policy monitoring, evaluation, and recommendations
   a. Continue developing an APCD in alignment with other digital infrastructure and house it within the new Health Care Authority.
   b. Continue implementing New Mexico's HIE (SYNCRONYS) in alignment with other digital infrastructure and use single sign-on integration for providers.

5. **Use legislation or administrative rule-making mechanisms to access additional data sources** that will inform health care cost monitoring, such as posted rates and information on consumer premiums and cost-sharing.

These 11 recommendations can help New Mexico build the infrastructure needed to implement cost-saving measures and represent a data-driven, evidence-based approach that the state can build on in continuing its work to provide the best possible care for New Mexicans.

Background

Health Care Cost Drivers

Health care costs keep rising, especially in the United States, but also worldwide (Kurani and Cox 2020). One group of actuaries projects a 7.0 percent increase in U.S. health care costs for 2024, which is even higher than the projected increases for 2022 and 2023 (Skoog et al. 2023). Health care costs increase due to changes in prices, utilization, and patient make-up (Glickman and Weiner 2020). Specific drivers of these increased costs include:

- Increased use of services, especially as insurance coverage has expanded in the United States, increasing access to services
- Aging populations with more chronic conditions
- Greater access to advanced therapies and technologies
- Higher costs for salaries and benefits for health care workers, including for traveling workers (who have increased due to workforce shortages)
- Higher prescription drug prices
- Higher medical device prices
- Increased administrative costs (American Hospital Association 2021; Glickman and Weiner 2020; Skoog et al. 2023; Turner et al. 2023)

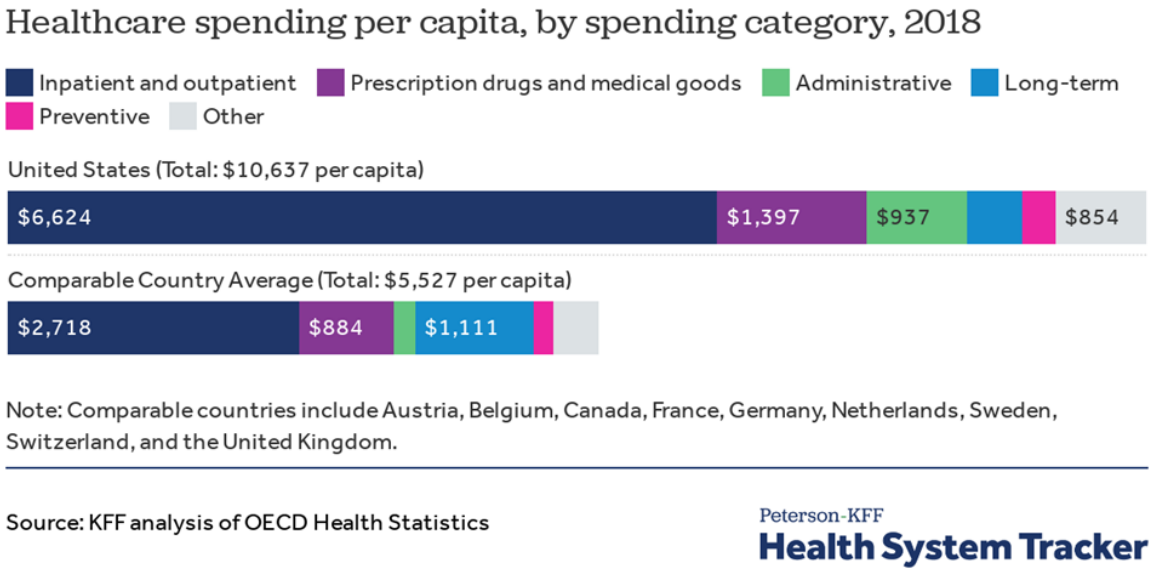
Hospital consolidation is also driving price growth, as mergers tend to increase prices for services (Glickman and Weiner 2020). Vertical integration of physician practices and hospitals also seems to have led to price increases (Ibid.). Part of the rising costs for states is that the U.S. population has increasingly shifted toward public insurance (i.e. Medicare and Medicaid) as the population has aged, which means that states pay more of the health care bill (Ibid.). Even so, nationally, commercial spending continues to exceed public payer spending (Bailit 2022).

Approximately 25 percent of U.S. health care spending is considered “wasteful,” including “services and processes that are either harmful or do not deliver benefits” and “excess costs that could be avoided by replacing services or products with cheaper alternatives that have identical or better benefits” (Peter G. Peterson Foundation 2023). Examples of waste in the U.S. health care system include administrative complexity, inconsistent pricing, failures of care delivery (e.g., errors and adverse events), low-value care (e.g., unnecessary medical interventions), fraud and abuse, and failures of care coordination (including incomplete electronic health records (EHRs) and lack of communication between providers) (Ibid.).

U.S. Health Care Costs vs. Comparable Countries

Although health care costs are rising worldwide, they were already higher in the United States. Most of the additional U.S. health care costs compared to peer nations "go to providers for inpatient and outpatient care," as detailed in Exhibit 1.

Exhibit 1. Health Care Spending Per Capita by Category, 2018 (Kurani and Cox 2020)



One study found that approximately 60 percent of the difference in spending (Turner et al. 2023) was, attributable to:

- Administrative costs of insurance (approximately 30 percent)
- Physician and nurse salaries (approximately 15 percent)
  - Note that wages are "determined in the context of U.S. labor markets and may also be influenced by levels of educational debt" (Ibid.).
- Prescription drug costs approximately 10 percent)
  - The United States "compares favorably on prices for unbranded generic drugs," but prices for branded drugs are "two to three times those in other OECD countries" and "account for approximately 80 percent of prescription drug expenditures in the U.S." (Ibid.)
- Machinery and equipment investments (<5 percent)
  - The United States was not found to spend more than other OECD countries on capital expenditures outside of medical machinery and equipment costs (Ibid.).

The U.S. population also has higher rates of obesity, diabetes, heart disease, and comorbid chronic conditions than other OECD countries, which lead to higher health care costs (Ibid.).

Administrative Costs

Administrative costs are defined as “the nonclinical costs of running a medical system” (Cutler 2020). They account for one-quarter to one-third of total U.S. health care spending (Ibid.), amounting to approximately half a trillion dollars per year (Fiedler 2023). Administrative costs may be associated with insurance (e.g., eligibility, coding, prior authorization, billing submissions) or with general workplace administration (e.g., human resources, quality reporting and accreditation) (Turner et al. 2023).

Some administrative costs are necessary—e.g., transactions must occur for bills to be paid, and credentialing of providers is certainly a necessity (Fiedler 2023). However, the United States spends more than comparable multipayer systems on administrative costs (Cutler 2020). A major source of the higher U.S. administrative spending vs. other countries is our reliance on “a menagerie of public and private payers, each of which sets its own rules for interactions with providers” (Fiedler 2023). Federal legislation aimed at reducing administrative costs has been posed since the 1990s, starting with increased standardization, promotion of EHRs, and encouraging interoperability (Cutler 2020). Despite reforms, there are still areas where administrative costs remain high or where reforms have failed to deliver on the promises of lower costs and interoperable technology, e.g., prior authorization and quality reporting.

Administrative costs impact the health care system at every level. The federal and state governments, which are responsible for coordinating massive health care programs like Medicare and Medicaid, have costs related to claims payment and quality measurement (Cutler 2020). Payers have costs related to claims payment, prior authorization, quality assurance, credentialing, customer service, taxes, and general business overhead (Ibid.). Providers and health care organizations, including hospitals, have costs related to claims and billing, prior authorization, quality measurement, technological interfaces (e.g., EHRs), credentialing, customer service, and general business overhead (Ibid.). These costs can multiply enormously as the system grows in complexity, (e.g., where many hospital staff are needed to keep track of different prior authorization policies among different payers, and so forth) Administrative costs become “baked into the health care cost structure” and eventually increase costs to taxpayers and policyholders (Ibid.).

Although federal-level polices can play a significant role, states also have the flexibility to pursue a variety of strategies to address administrative costs, including controlling health care cost growth, regulation that reduces prices, and promoting payment reform (Chernew et al. 2021).

Administrative Costs in New Mexico

New Mexico State Context

New Mexico has unique demographics among U.S. states. With a population of approximately 2.1 million people, half of the state’s population resides in just three of its 33 counties, representing the metropolitan areas of Albuquerque, Las Cruces, and Santa Fe. However, a notable portion of the state’s population (7 percent) resides in frontier or subfrontier areas based on population density.

Twenty-four of New Mexico's 33 counties have population densities less than 15 persons per square mile (U.S. Department of Health and Human Services, n.d.). The state has a significant rural population but still delivers health care to most citizens in more urban settings. New Mexico is 50 percent Hispanic or Latino, nearly 36 percent white alone, and 11 percent American Indian and Alaska Native (U.S. Census Bureau, n.d.b). In the state there are 23 federally recognized tribes, with 26 tribal areas and 40 Indian Health Service facilities (Indian Health Service, n.d.; Native American Election Information Program, n.d.; U.S. Census Bureau, n.d.a). The American Indian population means that the state must coordinate with the Indian Health Service and tribal health clinics to ensure appropriate access to health care.

According to the U.S. Census Bureau, New Mexico has the highest rate of public insurance enrollment in the nation (51.2 percent), well above the national average of 37.2 percent (U.S. Census Bureau 2023). As of July 2023, approximately 39 percent of the population was enrolled in Medicaid, with more than 80 percent of those enrolled in managed care (Centers for Medicare & Medicaid Services, n.d.; U.S. Census Bureau, n.d.b).[5] Approximately 21 percent of the population is enrolled in Medicare (Norris 2023; Scrase and Comeaux 2022). As of 2021, approximately 42 percent of people in New Mexico had employer-sponsored coverage,[6] and approximately 10 percent were uninsured (Conway and Branch 2022). Because New Mexico's population is covered by public insurance at such high rates, health care facilities tend to have less of a budgetary cushion derived from higher payments through private insurers.

Analysis of Administrative Costs in New Mexico Hospitals

To compare New Mexico hospitals with hospitals across the United States, NORC conducted an analytic review of Hospital Cost Report Information System (HCRIS) hospital cost report data, IRS 990 forms, and various rule-making files . **Based on the conducted analysis, we found the relative burden of administrative costs in New Mexico's hospitals to be comparable to hospitals** across the United States. Administrative costs in both New Mexico and hospitals nationwide have been **increasing at a similar rate over the past 15 years**. On an individual hospital level, almost every U.S. hospital has increasing administrative costs relative to total costs, showing that this is a common problem.

Although administrative costs are relatively similar, there are specific types of New Mexico hospitals that have significantly higher administrative costs proportional to their total costs. Our analysis found:

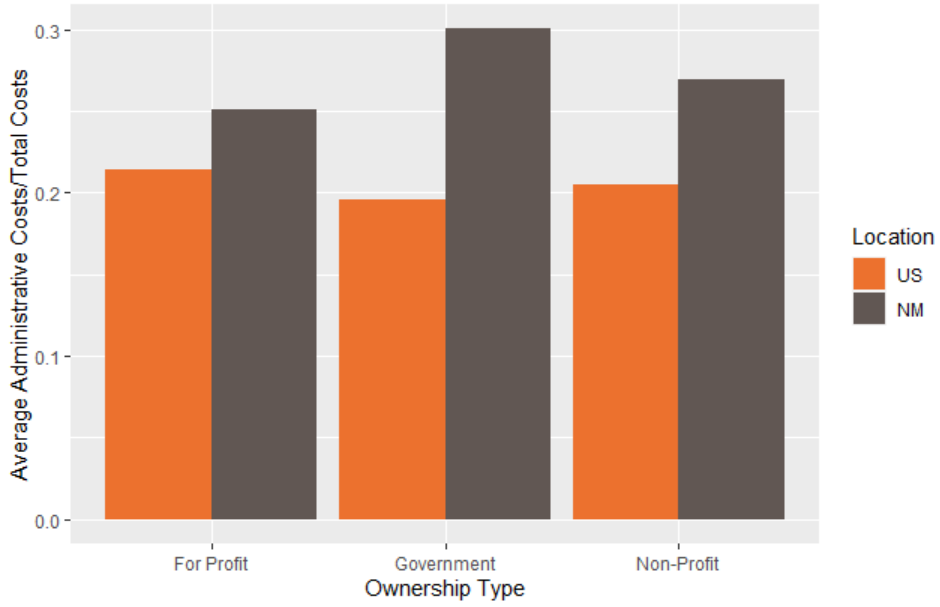
- Government-owned hospitals in New Mexico have a higher burden of administrative costs than other such hospitals in the United States. In addition, the administrative costs for government-owned hospitals (e.g., Indian Health Service [his] hospitals) are higher than both nonprofit and for-profit hospitals in the state (Exhibit 2).

[5] NORC analyzed CMS eligibility data as of July 2023 as well as 2022 U.S. Census Data.

[6] Employer-sponsored coverage includes federally funded programs such as retired and active-duty military, federal employee coverage, and the Indian Health Service.

- **A larger proportion of New Mexico hospitals have 10 beds or fewer (9.7 percent) and are rural (67.6 percent)** than non-New Mexico U.S. hospitals (3 percent and 46 percent, respectively). Smaller, rural hospitals have some of the same general overhead fixed costs as larger hospitals (e.g., cost of an EHR), which can increase their proportional administrative costs.
- New Mexico **hospitals tend to have inpatient days per available beds;** however, this may be due to New Mexico having more hospitals that operate at lower volumes than in other states.

Exhibit 2. Proportion of Administrative Costs to Total Costs by Ownership Type



New Mexico Context—Related Initiatives

All-Payer Claims Database (APCD)

In 2019, New Mexico authorized funding for an APCD. APCDs are databases that collect medical, pharmacy, and dental claims from all private and public payers, as well as eligibility and provider files. They aim to assist improvements in efficiency, affordability, and cost transparency by centralizing data from multiple sources. APCDs have been used in other states to identify millions of dollars in spending on low-value care (Budros et al. 2020). Implementation of New Mexico's APCD was originally slated for late 2023, but it is unclear where this currently stands.

Health Information Exchange (HIE), SYNCRONYS

New Mexico's designated HIE, SYNCRONYS, uses an Orion Health software platform and leverages partnerships with Collective Medical and the Rhodes Group to deliver high-value solutions. Leveraging CMS's 90/10 funding for the MMIS-R redesign, wherein the federal government pays 90% of the bill,

the HIE now integrates with the developing MMIS, which should enable more streamlined access to data and information.

The central aim of the HIE is to exchange a core dataset (the U.S. Core Data for Interoperability [USCDI]) among New Mexico's hospitals, skilled nursing and long-term care facilities, tribal/IHS hospitals and clinics, home health, hospice, behavioral health clinics, and independent clinics, as well as corrections facilities and detention centers. The USCDI includes patient demographics, allergies, encounter history, diagnoses, medications, insurance information, immunizations, procedures, laboratory results, pathology reports, radiology reports, and clinical notes.

1115 Waiver Programs

New Mexico's Medicaid and Children's Health Insurance Program (CHIP) are predominantly administered under a federal 1115 demonstration waiver approved by the Centers for Medicare & Medicaid Services (CMS). The current demonstration, Centennial Care 2.0, will expire at the end of calendar year (CY) 2023. In December 2022, New Mexico submitted a five-year renewal application for its 1115 waiver demonstration, with the aim to reinstate and/or enhance its 1115 waiver programs. The renewed plan will be called Turquoise Care and will become effective January 1, 2024, through December 31, 2028. New initiatives in the 2024 to 2028 waiver include continuous coverage for children up to six years of age, a pilot for home-delivered meals, Medicaid services for high-need justice-involved populations, and a pilot for chiropractic services.

Health Policy Commission (HPC)

New Mexico's Health Policy Commission was established by a legislative act in 1991 (1991 NM Laws, Chp. 139, Sec. 1-2) (Lopez et al. 2007). The commission was an independent state agency whose function was to provide a forum for the discussion of health policy and planning issues and for the creative exploration of ideas, issues, and problems regarding health policy and planning, including interrelations with education, the environment, and economic well-being. For several years, a key responsibility of the HPC was reporting on the Hospital Inpatient Discharge Dataset (HIDD), collected by the New Mexico Department of Health. The HPC was defunded and shut down a decade ago. However, the authorizing language remains, and its governing statutes are the Health Policy Commission Act – Chapter 9-7-11.1, 11.2 NMSA 1978 and the Health Information Systems Act – Chapter 24-14A-1 NMSA 1978.

New Mexico Health Care Authority

In November 2023, New Mexico announced that it would launch a new agency on July 1, 2024, the New Mexico Health Care Authority (HCA) (New Mexico Human Services Department, n.d.). The HCA merges teams from the New Mexico Human Services Department, General Services Department, and New Mexico Department of Health to create a single united agency focused on health care and safety net services for the people of New Mexico. NORC reviewed the HCA strategic and transition plans and took the state's vision for the HCA into account in developing the recommendations that follow.

Contract Overview

In August 2023, the New Mexico Legislative Council Service, acting on behalf of the New Mexico Interim Legislative Health and Human Services Committee (LHHS), funded NORC at the University of Chicago to "conduct an analysis of methods to reduce administrative costs in the health care system in New Mexico, which shall: identify, describe and analyze methods to reduce the administrative costs in the health care system and provide recommendations for health care administrative cost reduction," and subsequently "discuss the possible pros and cons of the methods identified." This report represents the culmination of three and a half months of work in analyzing administrative cost reduction methods. However, attempting to analyze administrative costs alone, as per the scope of the contract, is challenging because administrative costs do not exist in isolation. They are a part of the larger health care system and an important health care cost driver. We took the approach of researching and recommending targeted reforms to reduce administrative costs; however, some of our recommendations move more into the realm of systemic cost drivers than pure administrative costs, as the two are often challenging to separate.

When reviewing recommendations, it is important to remember that administrative processes were designed with good intentions and often serve to temper cost increases (such as using prior authorization to reduce unnecessary care), so there are trade-offs to reducing administrative costs. In addition, policy changes in one domain can impact administrative costs elsewhere in the system—one interviewee described this phenomenon as "squeezing the balloon." Reductions in administrative processes also often mean reductions in jobs, including local jobs in hospitals and health care organizations. These and other trade-offs make even simple administrative cost reductions politically challenging. More systemic shifts will have even more trade-offs and upfront barriers, which makes the coming work of the legislature and the state—i.e., the actual implementation of recommendations—the truly challenging work.

Findings and Recommendations

To develop our recommendations, we reviewed and analyzed the stakeholder interviews and an extensive collection of related online documents to identify relevant and important themes and findings and provider and other relevant data. We wanted to identify areas of agreement between the literature and stakeholders, and therefore focused on making recommendations that address stakeholders' biggest concerns. To refine our recommendations, we reviewed them with NORC staff members and New Mexico state policy experts and worked to ensure that they build on the activities, policies, and legislation that New Mexico is in the process of implementing.

As detailed in our contract for this work, our recommendations focus on *administrative* cost reduction and do not address a complete list of health care-cost drivers, (e.g., clinical costs or pharmacy prices). Nevertheless, some of our recommendations address the need for broader change than in the administrative costs area alone. Specifically, we recommend a health strategy and impact council to work toward both administrative cost reduction and addressing rising health care costs in the state. As part of our work, we also identified actions that may be useful in improving other aspects of health care (e.g., patient access and quality) but that we do not recommend for administrative cost reduction due to lack of evidence that they appreciably reduce administrative costs (See Appendix C).

Of course, there are important limitations to our recommendations. Although promising efforts are underway, we do not yet know the impact of newer health care policies in New Mexico, (e.g., gold-card programs,[7] streamlined provider credentialing, the establishment of the Health Care Authority, House Bill 75 [HB 75, "Medical Malpractice Act"] and its impact on workforce and finance, and MMIS-R). Since cost impact analysis of these policies is beyond the scope of our contract, we did not conduct economic or actuarial analyses to estimate these more recent administrative cost impacts.

Our findings and recommendations focus on three broad categories: 1) a series of short-term legislative packages to enhance uniformity and consistency across payers; 2) a short-to-medium-term commissioning of a special report or development of a legislative committee to review and suggest reforms regarding medical malpractice in New Mexico; and 3) a longer-term committee to develop a strategic plan to implement a healthy strategy and impact council.

Develop Legislative Packages to Enhance Uniformity and Consistency Across Payers

To enhance uniformity and consistency across payers, New Mexico has already implemented two reforms that are key recommendations in the literature for administrative burden reduction, streamlined provider credentialing, and a gold-card program for prior authorization (PA). Providers previously faced

[7] Originally developed for Medicare Advantage plans, gold cards exempt physicians from prior authorization requirements if a certain percentage—usually 90%—of the physician's requests were approved in the preceding 12 months (O'Reilly 2022).

long waits, up to 45 days, to get new providers credentialed and into the system, involving significant back and forth. Multiple stakeholders identified provider credentialing reform as a top priority. However, stakeholders also shared that multiple efforts are already underway in New Mexico to address this, including shortening physician credentialing turnaround time and a policy and corresponding systems for a single credentialing process. Given these efforts, NORC did not develop additional recommendations on this topic. A stakeholder also explained that the state just put in place a gold card program for prior authorization so that when providers "are being approved 90 plus percent of the time, they essentially get the equivalent of a gold card, and they are exempt from these prior authorization requirements." These existing reforms form a strong foundation for continued streamlining and improvements to both the prior authorization and credentialing processes.

Recommendation 1: Standardization and reform of prior authorization practices

Reforming prior authorization is one of the priority recommendations for reducing administrative burden that interviewees most frequently discussed. There are many possible prior authorization reforms—including designating "gold card" providers, which New Mexico recently implemented. Additional considerations for prior authorization reform include selective use of prior authorization, standardizing prior authorizations across payers, and using a fully electronic prior authorization system.

Pros:

- Ease provider burden
- Promote clinically sound PA
- Comply with CMS proposed rule on interoperability

Cons:

- May be difficult to get all payers on board
- Cost/burden reduction will not be as effective if all payers are not on board
- Requires HCA staffing to implement

1a. Encouraging plans to selectively use prior authorization

NORC recommends that New Mexico consider ways to encourage plans to selectively use prior authorization, which could be done through requirements for the state's Medicaid program and public insurance, requiring health plans to track certain metrics, or eliminating prior authorization requirements for certain services. As the prior authorization's time and cost impact on providers have become apparent, provider groups have called for reviews of prior authorization requirements to ensure that prior authorization is only used for select services from which patients and the health system would benefit (American Medical Association et al. 2018). One researcher suggests that the state "could encourage plans to conduct regular certification [of prior authorization requirements] to determine if all of the rules are still needed. And it could sponsor studies about how much use is deterred with different types of prior authorization" (Cutler 2020). The state could ask health plans to "track metrics about rationales for denials and reasons for overturning denials on appeal to make informed decisions about the effectiveness of the criteria used. Regular review can help identify services, particularly new and emerging therapies, where prior authorization may be warranted" (Crespi-Lofton 2020). Stakeholders agreed, recommending that prior authorizations only be used "for those services that really need it" and that the state could push health plans "to reduce the number of things that they do prior approval on." One stakeholder we

interviewed mentioned that Indiana recently reviewed prior authorization requirements and eliminated the need for prior authorization on the 50 most frequently used codes.

1b. Standardizing the list of services that require prior authorization across payers

NORC recommends that New Mexico standardize the list of services that require prior authorization across payers to eliminate the administrative burden of navigating the variation in prior authorization requirements and procedures. Physicians, through the American Medical Association, "have sought to standardize services requiring prior authorization. Creating a standardized list of services that must go through a prior authorization process for all payers would help to reduce the time burden and administrative frustrations" (Turner et al. 2019). Stakeholders also recommended standardization of prior authorization policies. One stakeholder explained that standardizing the services requiring prior authorization is "an aspirational goal, but I'm not sure in reality how realistic that is because everybody wants whatever their thing currently is because they think that there's some rationale for it." The American Association of Family Physicians recommends that, after sunsetting unnecessary prior authorizations, those that remain "should be standardized, including reliance on evidence-based criteria" (AAFP 2023). The state could standardize prior authorization across Medicaid managed care organizations (MCOs) through contracting and could consider legislation or additional administrative rules to bring other payers onto the same standardized system.

1c. Using a standardized electronic interface for prior authorization

NORC recommends that New Mexico adopt a standardized electronic interface for prior authorization, aligned with the proposed federal rule on interoperability. One evaluation found that using electronic prior authorization (ePA) could save an estimated $9.64 per prior authorization transaction (The Commonwealth Fund 2022). Among providers, ePA use was associated with shorter average time for prior authorization decisions (Salzbrenner et al. 2022). Once an ePA system is established, enhancements can be made, such as connecting the ePA system to the EHR in real time "to populate required information so that it does not have to be entered manually" (Crespi-Lofton 2020). Furthermore, using a standardized electronic interface with a specific application programming interface (API) may soon be required for all CMS programs (i.e. Medicare, Medicaid and CHIP, and the Marketplace), as part of a proposed rule on interoperability (DHHS Office of the Secretary 2022). Employer-sponsored insurance is exempt from the proposed rule but can still adopt the standardized electronic interface as a way to streamline prior authorization (Pestaina et al. 2023). Stakeholders who have used an ePA system find it to be "a lot easier" and welcome further adoption of a standard electronic system.

Recommendation 2: Develop and implement an administrative simplification package to standardize billing forms and claims submission across payers

NORC recommends developing and implementing an administrative simplification package for claims and billing, focusing on standardizing rules and forms to the greatest extent possible across payers. Studies suggest that administrative burdens can be reduced by implementing a single set of rules that require a standard set of payment requirements, forms, and data exchange requirements.[8] A study in Minnesota shows that standardization of billing is "reducing the need for phone-based follow-up and questions between providers and payers, helping reduce an estimated $15.5 million - $22 million annual expense statewide for the calls" (Center for Health Care Purchasing Improvement, n.d.).

Pros:

- Ease provider and payer burden
- Increase billing efficiency
- Reduce claim resubmissions and follow-ups

Cons:

- May be difficult to get all payers on board
- Requires HCA staffing to implement

Among New Mexico stakeholder interviews, claims and billing standardization was one of the top-ranked recommendations to address administrative burden. Stakeholders said that getting a claim paid currently "seems to be unreasonably difficult" because "every insurance has its own set of parameters and rules and criteria." They were careful to note that although standardization is a great goal, since federal requirements differ by payer, complete standardization may not be possible. For this reason, the state may need to use model contracts and other enforcement methods to assure uptake of the standardized procedures.

Recommendation 3: Alignment of state and payer quality metrics and with federal ones, including appropriately limiting use of additional metrics by payers

Several researchers have recommended strategies to reduce the administrative burden of quality measurement requirements by "harmonizing quality metrics" across payers (The Commonwealth Fund 2022). We recommend that New Mexico work to align state and payer quality metrics, including alignment to federal quality metrics such as the CMS Core Quality Measures. New Mexico should also work to appropriately limit the use of additional metrics by payers. Quality reporting is an "attractive" area for standardization "as it could likely both reduce administrative costs and increase the utility of the resulting quality data by increasing provider-level sample sizes and easing cross-payer comparisons" (Fiedler 2023). It is noted that physicians rarely treat patients differently based on their insurer, so "it does not make much sense to have a separate

Pros:

- Ease provider and health plan burden

Cons:

- Unlikely to produce significant savings in isolation
- May be difficult to get all health plans on board
- Loss of state-specific metrics

[8] Please see Appendix D for additional findings from the literature review for more examples

quality assessment at the provider level for patients insured by Medicare, Medicaid, and private insurance" (Cutler 2020). Suggestions include "determining a core set of quality measures" and requiring insurers in the state to use them (The Commonwealth Fund 2022). Minnesota, for example, enacted legislation by which providers "are required to report on a publicly-defined set of quality metrics. Health plans can choose whether to use those measures in their performance contracts but cannot insist on other metrics" (Cutler 2020).

Stakeholders agree with research suggesting that standardization of quality measures is a feasible and beneficial approach to reducing administrative burden. Stakeholders mentioned that quality measures requirements are burdensome, particularly if each payer requires a different set, with one person noting that it "is questionable if the reporting is providing value." One stakeholder called "reducing the reporting cadence and the magnitude of the reporting and the list of measures" a "huge opportunity" for the state.

Recommendation 4: Require appropriate standardization of organizational contracts

Pros:

- Reduce burden of contract variation
- Increase compliance with standardization efforts and other strategic priorities

Cons:

- Effort to renegotiate existing contracts

NORC recommends that New Mexico require standardized organizational contracts for MCOs, including administrative simplification, standardization and reform of prior authorization, alignment of quality metrics, and submission of data to the state APCD and HIE. Multiple sources recommend model provider contract structures for health plans to reduce administrative costs, since variations in contracts by multiple health plans have been found to significantly increase the time and labor it takes to verify information (Chigurupati and Kocher 2021). One analysis found that standardized provider contracts "increase the effectiveness of automated fraud detection and could reduce compliance costs by limiting the number of providers subject to the highest level of scrutiny" (Scheinker et al. 2021). Stakeholders registered significant concern with how health plans would react to a push toward standardization, noting that there could be "a huge outcry" from health plans if such an approach were encouraged. Using standardized Medicaid MCO contracts gives the state an opportunity to enforce administrative simplification and cost containment policies, such as requiring standardized billing forms and processes, standardized prior authorization requirements, standardized data submission and reporting, adherence to growth caps, and more.

Commission a Special Report or Legislative Committee to Recommend Medical Malpractice Reforms

In recent years, medical malpractice insurance has become a significant nonclinical cost driver in New Mexico. Recommendations 5 and 6 focus on medical malpractice in the state and provide short-term

recommendations that can set the state up for long-term effective reforms targeted at reducing administrative burden.

Recommendation 5: Conduct an objective and comprehensive study of the impacts of the state's medical malpractice requirements on hospital budgets and the health care workforce

Pros:

- Understand the full picture of medical malpractice and its impacts across the state
- Eventually reduce outmigration of providers

Cons:

- Delays relief for vulnerable providers
- Politically fraught endeavor

NORC recommends a comprehensive study of the impact of the state's medical malpractice requirements on hospital budgets and the health care workforce. Medical malpractice impacts hospital budgets and will likely eventually impact the state budget when hospitals need to negotiate higher rates to pay their premiums. House Bill 75 of the 2021 Regular Session of the New Mexico Legislature, "Clarifying and Modernizing the Medical Malpractice Act (HB 75)" enacted several reforms that appear to have had unintended consequences for the health care system. HB 75 changed the definitions of "occurrence" and "outpatient health care facility," increased the limits on medical liability damages, changed the statute of limitations for medical liability claims, and addressed the funding of the state's Patient Compensation Fund (PCF)[9] (The Doctors Company 2023). A follow-up bill, HB 11, protected outpatient facilities that are not majority-owned or controlled from the higher limits set by HB 75 (Ibid.).

Stakeholders discussed medical malpractice extensively, with several interviewees stating that medical malpractice reform is their priority recommendation for reducing administrative costs in the state. Given the breadth and depth of concern about medical malpractice in New Mexico's health care market and the range of stakeholders impacted by recent changes, it is evident that a complete review and analysis of the implementation and way forward for HB 75 is required. Recommendation 6 discusses potential recommendations to consider while the study is underway.

[9] The New Mexico Professional Liability Fund Act of 1976 established a patient compensation fund. The fund is a "state-established liability funding mechanism that provides medical malpractice coverage in excess of the primary insurance requirements of the applicable state. The fund limits the amount of damages that may be awarded against an enrolled health care provider, thus limiting their liability and lowering medical professional liability insurance premiums" (Cunningham Group, n.d.).

Recommendation 6: In the interim, consider several actions relative to House Bill 75 of the 2021 Regular Session of the New Mexico Legislature entitled "Clarifying and Modernizing the Medical Malpractice Act (HB 75)," including:

6.a Synonymously define:

i. *"Malpractice claim" and "occurrence" so that a single injury event is recognized and treated as a single claim or occurrence*

ii. *"Medical care and related benefits" to be only costs paid by or on behalf of the injured patient and not tied to billed charges*

Pros:

- Removal of most contested aspects of the law

Cons:

- Will likely not resolve concerns of insurers or alleviate burden of hospitals
- Politically fraught endeavor

6.b Prohibit "venue shopping" and obligate a case to be heard in the county where the health care provider is located, or where the patient resides, unless there are well-defined and limited criteria for a change in venue.

The rationale for these recommendations is based on stakeholders' concerns about increased costs to providers and taxpayers resulting from HB 75. HB 75 raised the cap for malpractice awards from $800,000 to $5 million and considers outpatient providers the same as hospitals in terms of maximum malpractice settlement value (Grubs 2023). As a result, insurance companies are less inclined to offer malpractice insurance, and providers, especially those in outpatient facilities, have been unable to obtain coverage (Ibid.). The intentions of HB 75 seem to have been to modernize medical malpractice in the state, to increase payouts to persons who have been victims of medical malpractice, and to make the PCF solvent. However, there appear to have been unintended consequences—such as making it difficult, and more expensive, for health care facilities to buy malpractice coverage and making the state less attractive to new health care providers who are concerned about having malpractice suits follow them throughout their careers.

Stakeholder Feedback

Approximately half of interviewees expressed concern about the changes to medical malpractice laws. Feedback highlighted three primary themes: 1) concerns about litigiousness, 2) difficulties finding and paying for insurance, and 3) concern about exacerbating the workforce shortage. Overall, there is significant concern about a potential impending "crisis point" where New Mexico finds itself "in a situation where hospitals can't find coverage" and they must close.

Concerns about Litigiousness

Stakeholders noted two key concerns that give New Mexico a reputation for being "overly litigious"—unfounded lawsuits and venue shopping. In a lawsuit in New Mexico, a person "can claim punitive damages at the beginning before proving anything." In most other states, by contrast, a person has "to prove that there were actual damages, and you have to prove that there was a high likelihood of gross

negligence before you can even start to make an allegation and a claim for punitive damages." Other states also require that the error be "an intentional error, that somebody purposely did something." One stakeholder noted that "bad outcomes do not equal malpractice... but there is usually a settlement" anyway. Venue shopping is another concern. Stakeholders explained that New Mexicans are allowed to move a case from one jurisdiction to another and noted that plaintiffs search for a personal representative who lives in one of the jurisdictions known to be "extremely plaintiff friendly and extremely liberal with their jury awards." Since we did not conduct a study of these statements, we relied on stakeholder comments here.

Malpractice Insurance

Since House Bill 75 passed, one stakeholder noted that "the insurers themselves have, from what I have seen, been losing money. They have been paying out more in claims than they have collected in premiums." Not surprisingly, then, insurers have become wary of insuring New Mexico hospitals and purportedly charge high premiums when they do so. According to stakeholders, medical malpractice premiums are "about double" in New Mexico vs. surrounding states. One hospital administrator noted that they approached 19 insurance companies and only one agreed to cover them; the rest said that "New Mexico is a bad environment for insurance.... it's too litigious." Another hospital "had to go to almost 40 insurers before [they] got one, and when [the hospital] did get one, I think [the rate] almost tripled." Another hospital's insurance premium was said to have gone up "18 million dollars." Stakeholders explained: "That's money that should be going to improve care and expand services, but it's going to the insurances, and ultimately it's going to the trial lawyers." There is concern that the insurance rate "has a major impact on patient care and patient access" because hospitals "have less money to spend on patient care and new services, or maintaining the services that they have in their communities, especially in our rural communities." Since we did not conduct a study of these statements, we relied on stakeholder comments.

Workforce Shortage

Like other states, New Mexico has an ongoing health care workforce shortage, and stakeholders fear that the medical malpractice environment is exacerbating the shortage. One stakeholder explained that malpractice insurance is an "untenable expense for a lot of our providers, particularly our small rural providers, or people that do not have a well-established practice. I guess that is one of the reasons why we are not getting new providers coming into the state and why we are losing people who have trained here." A hospital administrator notes that even at a hospital, which pays the physician's malpractice premiums, "physicians still do not want to come here. Because even though they may not be paying the insurance premium, the concern is about the potential of ... a malpractice suit; they have to carry it with them throughout the rest of their career." One stakeholder succinctly summarized: "We're losing physicians. We may lose some hospitals."

Develop a Strategic Plan for Implementing a Health Strategy and Impact Council

Recommendation 7: Fund and develop a health strategy and impact council to provide oversight and monitoring of New Mexico's digital infrastructure and cost containment efforts.

In many states that have successfully contained administrative costs, there are funded policy bodies—made up of paid staff to conduct day-to-day policy, operations, and analytic work—as well as an independent advisory and oversight group. **NORC recommends that, as an approach to addressing health care cost drivers, including administrative costs, New Mexico fund such a health policy development and analytics entity, e.g., a health strategy and impact council.** The council—designed to make recommendations and monitor implementation of approaches to strengthen New Mexico's health care market—would monitor trends, and research, evaluate, and propose policies, to ensure that state policy-makers and administrators have timely information for decision-making.

Pros:

- Dedicated team to review and recommend policy and analyze data
- Would fit within strategic structure of HCA
- HPC law is already on the books in NM

Cons:

- Requires funding
- Need to find a home within or beside the HCA

Eight states—Connecticut, Delaware, Massachusetts, Nevada, New Jersey, Oregon, Rhode Island, and Washington—"have established new independent commissions or increased the authority of an existing regulatory body to limit unnecessary growth in health spending" (Melnick 2022). Massachusetts was the first state to develop such a commission, in 2012, and therefore has the most evidence to support their work and successes. Several commonalities exist across effective state efforts at reducing cost growth by use of a commission, including: 1) developing the capacity of the state "to collect, assess the quality of, and analyze the health care spending data they receive to inform the state's specific data use goals" and 2) "measure, set, and enforce growth targets designed to lower costs and improve value across the health care system" (Ibid.). Stakeholders seemed receptive to the idea of a commission or council, so long as it is staffed with health care "expertise" and "access to data."

7a. House the Health Strategy and Impact Council within the HCA

NORC recommends that as New Mexico moves to a new Health Care Authority (HCA) that is integrating health care functions across state agencies, the state consider housing the council within the HCA, as long as it has the independence to work effectively. States with similar entities use various models, with some, like Massachusetts, having an entirely independent entity (the Health Policy Commission), while others, like Oregon, have an integrated team and governance structure (i.e., within the Oregon Health Authority). The council could be informed by the work of the HCA Offices of the Deputy Secretary for Analytics & Innovation, Director of Health Care Financing & Coverage, Director of

Medicaid, and Director of Strategic Planning. It could fit within Strategic Planning, if it is informed by these other offices and has a commission or other body made up of outside experts and stakeholders to provide input and advice. One of the first steps in developing a strategic plan to implement such a council will be to determine the best place to house it, according to state resources and best practices.

7b. Develop and fund the entity based on best practices. NORC recommends that in developing the health impact and strategy council, New Mexico consider the following:

- **Governance and staffing.** Best practices from states that have successfully slowed health care costs using a similar entity suggest that the team should consist of, or be advised by, experts and key stakeholders. New Mexico should also carefully consider intergovernmental collaboration, including with the office of the state attorney general and other relevant agencies. New Mexico should consider whether the state's already authorized Health Policy Commission (1991 NM Laws, Chp. 139, Sec. 1-2) could fulfill the proposed role, or whether statutory changes will be needed. (See also **Recommendation 7a**)
- **Policy scope and accountability measures.** The council should be able to develop enforceable policies to increase accountability and reduce costs. As New Mexico develops the entity, it should carefully consider its policy scope and what authority it has for accountability measures. Other states have used similar entities to enact policies such as growth caps, cost benchmarking, global budgeting for hospitals, and a review of potential mergers and acquisitions. (See **Recommendation 8.**)
- **Data access.** For monitoring purposes, the council should have access to a variety of data sources, including, at minimum, the state's APCD, HIE, and MMIS-R data. The state is already developing or modernizing databases, including MMIS-R and HIE (SYNCRONYS) and has an APCD in place. These databases are foundational for the data needed to set growth caps, develop rate benchmarking, and analyze other policies to control health care costs. (See **Recommendations 9 and 10**.)
- **Funding and resources.** Especially since New Mexico's Health Policy Commission was previously defunded, the state should carefully consider its role and purpose and work to ensure sustainable funding. Many states pursuing health care cost growth targets are participating in the Peterson-Milbank Program for Sustainable Health Care Costs.[10] NORC recommends that New Mexico explore whether this program would support the state in its goals.
- **Stakeholder engagement.** States that are currently implementing cost growth targets use different measurement strategies. As New Mexico considers implementing a cost growth cap, NORC recommends ongoing engagement with stakeholders regarding which data will be included in measurement and how cost growth will be measured.

[10] The Peterson-Milbank Program for Sustainable Health Care Costs provides resources to support state-led efforts to make health care more affordable (Milbank Memorial Fund, n.d.).

Recommendation 8: Through the health strategy and impact council, implement growth caps to mitigate health care cost drivers, including appropriate enforcement mechanisms.

Pros:

- Proven strategy to contain costs

Cons:

- Must identify enforcement mechanisms
- NM operating margins tend to be lower than in other states
- Must be sensitive to payer-mix limitations

Most existing health policy commissions are charged with mitigating health care cost growth drivers through growth caps. Growth caps have evidence of reducing the overall growth of health care costs. Massachusetts has had growth caps longer than any other state, and their data show significantly lower growth in health care spending—approximately 2.8 percent from 2012 to 2019 vs. approximately 4.4 percent growth nationally over the same time period (Massachusetts Health Policy Commission 2022; Telesford et al. 2023). This amounts to billions of dollars in savings. Commissions meet regularly to set statewide benchmarks for health care cost growth and then monitor progress toward these benchmarks. Benchmarking programs typically identify cost drivers across market segments, make recommendations to mitigate them, and produce reports on findings (Ario et al. 2019). Stakeholders were interested in growth caps but understood that growth caps will not be effective without an appropriate human and data infrastructure to support it. One stated, “A growth cap can be a good way, if you’ve got the right infrastructure and technical ability to monitor it and keep everybody accountable to it.”

In considering growth caps, New Mexico could also establish levers of enforcement for the health policy entity and/or Health Care Authority. All eight states with existing growth caps “currently use public transparency as a key strategy for accountability,” although stronger enforcement, such as financial penalties, is preferable (Melnick 2022). The Massachusetts commission “has the authority to require performance improvement plans from entities exceeding the cost growth target, and Oregon stipulates financial penalties for repeated unjustified growth above the target” (Ibid.). These enhanced enforcement capabilities of the Massachusetts and Oregon commissions may contribute to their successes in controlling health care cost growth.

Recommendation 9: Through the health strategy and impact council, monitor trends in health care spending, including reviewing federal funding opportunities and evaluating proposed changes in ownership or affiliation.

Pros:

- Gives state a chance to weigh in on proposed mergers and acquisitions
- Ensures state is well positioned to take advantage of appropriate federal opportunities

Cons:

- May have opposition from hospitals

NORC recommends that through the health strategy and impact council, New Mexico monitor trends in health care spending,

including reviewing federal funding opportunities and evaluating proposed changes in ownership or affiliation.

Several other states have set up similar entities to accomplish related goals. For example, the Massachusetts Health Policy Commission is charged with informing the legislature of trends in health care spending, recommending improvements for system efficiency, certifying and monitoring accountable care organizations (ACOs) and health plans, monitoring adoption of alternative payment models (APMs), supporting health care delivery and payment models, overseeing the effect of market changes, protecting patient access to services, and hosting public hearings (Dube and Orlando 2014). The Oregon Health Policy Board provides oversight to the Oregon Health Authority, creates programs to improve access to health care, publishes health outcome and quality-measures data for health plans, institutes evidence-based standards and practice guidelines, creates a baseline health benefit package for all health plans, informs the legislature on the advisability of changes to the health insurance market, and monitors workforce coverage (Oregon Health Authority, n.d.). Many of the activities under the purview of the Massachusetts and Oregon commissions may also be of value for New Mexico. The council could also review federal funding opportunities, including evolving and new health care models and grants to ensure that the state is maximizing available funding and choosing to participate in the models that best align with state priorities.

New Mexico may also be interested in rules that require the council to be notified of proposed transactions between health care organizations. For example, “In Massachusetts, providers and provider organizations must notify the Health Policy Commission and state attorney general of any material change in ownership or affiliation, defined broadly to include mergers, acquisitions, affiliations, joint ventures, partnerships, and other arrangements. If the proposed material changes are considered likely to affect the state’s ability to meet cost growth benchmarks, the commission can conduct a detailed impact review of the proposed change” (Melnick 2022). In this way, the health policy entity would have a chance to review and recommend for or against potential mergers and acquisitions and estimate the impacts such transactions would have on health care costs in the state. Stakeholders noted that the state is “extraordinarily worried” about the “toxic environment” that comes with mergers and acquisitions and private equity takeovers.

Recommendation 10: Ensure that the health strategy and impact council has access to state-administered databases (i.e., MMIS-R, HIE, and APCD) for policy monitoring, evaluation, and recommendations.

Experts emphasized the importance of what one researcher calls “establishing a common digital infrastructure” that seamlessly incorporates both administrative and clinical (EHR) data, in which payers and providers can see and utilize data for decision-making (Richman and Schulman 2023). Without

Pros:

- Can guide maturation and effective deployment of MMIS-R, HIE, and APCD
- Can use to understand state cost trends and monitor new programs

Cons:

- Entities housing these tools may push back with alternative agendas

accurate, timely data, state officials cannot monitor health care costs or effectively intervene to support the stability of the health care marketplace. HIEs, APCDs, and MMISs are all integral components of a common data platform. Stakeholders we interviewed rated interoperability as one of their top recommendations for administrative cost reduction, noting that data are currently fragmented or unavailable so that evidence-based decision-making is not always feasible.

New Mexico has undertaken and nearly completed a MMIS-R project to "establish an integrated, stakeholder-centric health and human services structure for the state in order to more effectively manage and deliver all HHS (Health and Human Services) services" (Hitzman 2021). The new MMIS-R will contain secure system integration capabilities, a fiscal module to adjudicate claims, a data warehouse with analytics and reporting capabilities, quality assurance tools such as audit coordination and fraud and abuse detection, benefit management service tools, and a unified public interface (Ibid.). Stakeholders noted that the MMIS will be housed under the new HCA, which is where NORC recommends housing all components of the common data platform.

The investment in the MMIS-R, as well as in the APCD and HIE, have been justified based on promises for reduced administrative burden and improvements in relevant health information to guide decision-making and program planning. Based on lessons learned in other states, interviewee feedback, status reports on digital infrastructure, and reviewing the Health Care Authority Transition Plan, we recommend that New Mexico ensure that tools such as the APCD, HIE, and MMIS-R are intentionally structured to understand and bend New Mexico's health care cost curve.

10a. Continue developing an APCD in alignment with other digital infrastructure and house under the new Health Care Authority

Multiple experts recommend implementation of an APCD to lower health care administrative costs by promoting price transparency and high-value care. One of the key recommendations of RAND's landmark Hospital Price Transparency Study, which we reviewed, is to "support the development and maintenance of APCDs and allow these APCDs to be used for price reporting purposes" (RAND Corporation, n.d.). States with existing health policy commissions rely on APCD data as a key component of their analytic and monitoring capabilities. New Mexico has started the process of building an APCD, but stakeholders interviewed expressed concern that the effort appears to have stalled, although they noted that the APCD will also be moving to the new HCA, which they hope will reinvigorate the effort. We were able to confirm with the New Mexico Department of Health that the APCD is currently in a user-acceptability testing stage and that it is expected to be in production in the second quarter of 2024. Another stakeholder expressed concern that the APCD and the forthcoming HIE (SYNCRONYS) will be "in competition" with each other, noting that they hope the state can help set specific functions, such as using the HIE for population health efforts and the APCD for price transparency.

10b. Continue implementing New Mexico's HIE (SYNCRONYS) in alignment with other digital infrastructure and using single-sign-on integration for providers.

An HIE can reduce provider administrative costs by simplifying data sharing across organizations. Furthermore, HIEs have been found to reduce overall health care spending by resulting in fewer duplicated procedures, reduced imaging, and improved patient safety (Menachemi et al. 2018). Stakeholders interviewed elaborated on the benefits that a well-functioning HIE could bring, noting that when "patients are transferred to a tertiary facility, they don't have to send the records also," which would reduce staff time spent on transfers. New Mexico's HIE (SYNCRONYS) appears to be nearing readiness. One stakeholder noted that there are plans to share data from the APCD within the HIE, making the HIE a very powerful tool for analysis, evaluation, and monitoring. Other stakeholders had concerns that the HIE will not end up being as useful as it could, noting that it needs an interface that makes it simple for providers to share their data as well as "single sign-on integration," so that providers "don't have to log in and out of different web browsers" to access the HIE alongside their EHR. It is unclear both how SYNCRONYS will interact with EHRs and whether the HIE will be housed under the new HCA like the MMIS-R and the APCD. Again, we recommend housing all three of these state-administered databases under the same authority to facilitate interoperability.

Recommendation 11: Use legislation or administrative rulemaking mechanisms to access additional data sources that will inform health care cost monitoring, such as posted rates and information on consumer premiums and cost-sharing.

In addition to the foundational data elements of MMIS-R, an APCD, and an HIE, we recommend that over time New Mexico consider collecting supplemental data from payers and providers to add depth and context to claims and clinical data. Massachusetts, for example, "regularly collects data on consumer premiums and cost-sharing, quality, Alternative Payment Model (APM) adoption, and provider price variation" from health plans (Ario et al. 2019). Based on the types of monitoring and analysis that New Mexico hopes to undertake, we recommend choosing which data sources would be most helpful and focusing on using legislation or administrative rulemaking (e.g., health plan accreditation) to ensure data access. Stakeholders noted that there are "huge opportunities in administrative analytics" if the state chooses to invest in data.

Pros:

- More context and depth of data for better-informed decision-making

Cons:

- Will need to bring payers on board for additional data submission
- Requires expertise to receive, maintain, and use the data files

In addition, CMS recently required employer-sponsored insurance (ESI) and marketplace health plans to post agreed rates with network providers, by service, as part of a payment transparency rule (Centers for Medicare & Medicaid Services 2023a). As such, starting in July 2022, more than 900 group health insurers across the United States posted about 500 terabytes of these data on publicly accessible (if not readily findable) websites, updated monthly. Such data would be critical for any rate benchmarking or price-setting activities the state may consider. While these data are publicly available, they are difficult to find and even more difficult to use and apply. However, with new legislation or administrative rulemaking (e.g., via health plan accreditation), the

state could consider requiring insurers to submit these transparency data to a state portal or the APCD in a specific format, with low additional burden to health plans.

Summary

New Mexico, like all states, is concerned about rising health care costs. The New Mexico Legislative Council Service, acting on behalf of the New Mexico Interim Legislative Health and Human Services Committee (LHHS), funded NORC to analyze methods to reduce administrative costs in the state's health care system. We conducted a literature review, spoke with 20 key informants, and carried out an analytic review of hospital cost reports. Then we synthesized our findings and developed 11 recommendations for New Mexico to consider. These recommendations include short-term legislation to enhance uniformity and consistency throughout the health care system, a medium-term report to lay out potential medical malpractice reforms, and a longer-term plan for implementing a health strategy and impact council that can help the state conduct sophisticated analyses and increase oversight of health care costs. These recommendations represent a starting point for the state; the hard work of implementing new policy and creating system change is yet to come.

Appendices

A. Works Cited

AAFP. 2023. “Prior Authorization and Step Therapy (Position Paper).” October 2023. https://www.aafp.org/about/policies/all/prior-authorizations.html.

American Hospital Association. 2021. “2021 Cost of Caring.” October 2021. https://www.aha.org/guidesreports/2021-10-25-2021-cost-caring.

American Medical Association, American Hospital Association, America’s Health Insurance Plans, Blue Cross Blue Shield Association, Medical Group Management Association, and American Pharmacists Association. 2018. “Consensus Statement on Improving the Prior Authorization Process.” American Medical Association. https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf.

Ario, Joel, Kevin McAvey, and Kyla Ellis. 2019. “Implementing a Statewide Healthcare Cost Benchmark:” Manatt Health. https://www.oregon.gov/oha/HPA/HP/HCCGBDocs/RWJ-Phase-5-Report-Cost-Benchmarking-Paper-December-2019.pdf.

Bailit, Michael. 2022. “What Is Driving Health Care Spending Upward In States With Cost Growth Targets?” *Health Affairs Forefront*, August. https://doi.org/10.1377/forefront.20220805.244579.

Berenson, Robert A, Jaime S King, Katherine L Gudiksen, Roslyn Murray, and Adele Shartzer. 2020. “Addressing Health Care Market Consolidation and High Prices.” https://www.urban.org/sites/default/files/publication/101508/addressing_health_care_market_consolidation_and_high_prices_1.pdf.

Bindman, Andrew, Marian Mulkey, and Richard Kronick. 2018. “A PATH TO UNIVERSAL COVERAGE AND UNIFIED HEALTH CARE FINANCING IN CALIFORNIA.” University of California, San Francisco. https://healthcare.assembly.ca.gov/sites/healthcare.assembly.ca.gov/files/Report%20Final%203_13_18.pdf.

Budros, Michael, Michael Chernew, and A. Mark Fendrick. 2020. “Utilization and Spending on Low-Value Medical Care Across Four States.” V-BID Health. https://vbidhealth.com/docs/APCD-LVC-Final.pdf.

Cai, Christopher, Jackson Runte, Isabel Ostrer, Kacey Berry, Ninez Ponce, Michael Rodriguez, Stefano Bertozzi, Justin S. White, and James G. Kahn. 2020. “Projected Costs of Single-Payer Healthcare Financing in the United States: A Systematic Review of Economic Analyses.” *PLoS Medicine* 17 (1): e1003013. https://doi.org/10.1371/journal.pmed.1003013.

Center for Health Care Purchasing Improvement. n.d. “Minnesota’s Health Care Administrative Simplification Initiative.” Minnesota Department of Health. https://www.health.state.mn.us/facilities/ehealth/asa/docs/factsheetadminsimp.pdf.

Centers for Medicare & Medicaid Services. 2023a. “Use of Pricing Information Published under the Transparency in Coverage Final Rule.” September 6, 2023. https://www.cms.gov/healthplan-price-transparency/public-data.

———. 2023b. “FY 2024 IPPS Final Rule Home Page.” October 25, 2023. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2024-ipps-final-rule-home-page.

———. n.d. “Filtered State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data.” Data.Medicaid.Gov. Accessed November 16, 2023. https://data.medicaid.gov/dataset/6165f45b-ca93-5bb5-9d06-db29c692a360/data?conditions[0][property]=state_abbreviation&conditions[0][value]=NM&conditions[0][operator]=%3D.

Chernew, Michael E., David M. Cutler, and Shivani A. Shah. 2021. “Reducing Health Care Spending: What Tools Can States Leverage?” The Commonwealth Fund. 2021. https://www.commonwealthfund.org/publications/fund-reports/2021/aug/reducing-health-care-spending-what-tools-can-states-leverage.

Chigurupati, Anuraag, and Bob Kocher. 2021. “Challenges and Opportunities for Administrative Simplification in US Health Care.” *Health Services Research* 56 (4): 578–80. https://doi.org/10.1111/1475-6773.13692.

Conover, Christopher J., and James Bailey. 2020. “Certificate of Need Laws: A Systematic Review and Cost-Effectiveness Analysis.” *BMC Health Services Research* 20 (August): 748. https://doi.org/10.1186/s12913-020-05563-1.

Conway, Douglas, and Breauna Branch. 2022. “Health Insurance Coverage Status and Type by Geography: 2019 and 2021.” U.S. Census Bureau. https://www.census.gov/content/dam/Census/library/publications/2022/acs/acsbr-013.pdf.

Crespi-Lofton, Judy. 2020. “AMCP Partnership Forum: Optimizing Prior Authorization for Appropriate Medication Selection.” *Journal of Managed Care & Specialty Pharmacy* 26 (1): 10.18553/jmcp.2020.26.1.55. https://doi.org/10.18553/jmcp.2020.26.1.55.

Crowley, Ryan, Hilary Daniel, Thomas G. Cooney, and Lee S. Engel. 2020. “Envisioning a Better U.S. Health Care System for All: Coverage and Cost of Care.” *Annals of Internal Medicine* 172 (2_Supplement): 7–32. https://doi.org/10.7326/M19-2415.

Cunningham Group. n.d. “New Mexico Malpractice Insurance.” Cunningham Group. Accessed November 14, 2023. https://www.cunninghamgroupins.com/medical-malpractice-insurance-by-state/new-mexico/.

Cutler, David. 2020. “Reducing Administrative Costs in U.S. Health Care.” Policy Proposal 2020–09. The Hamilton Project. https://www.hamiltonproject.org/wp-content/uploads/2023/01/Cutler_PP_LO.pdf.

Davis, Jessica. 2018. “JAMA: EHRs Fail to Reduce Administrative Billing Costs.” Healthcare IT News. 2018. https://www.healthcareitnews.com/news/jama-ehrs-fail-reduce-administrative-billing-costs.

DHHS Office of the Secretary. 2022. “Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children’s Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program.” Federal Registrar, Vol. 87, No. 238. https://www.govinfo.gov/content/pkg/FR-2022-12-13/pdf/2022-26479.pdf.

Dorn, Stan, and Matthew Buettgens. 2013. “Administrative Renewal, Accuracy of Redetermination Outcomes, and Administrative Costs.” Urban Institute. https://www.urban.org/sites/default/files/publication/24031/412921-Administrative-Renewal-Accuracy-of-Redetermination-Outcomes-and-Administrative-Costs.PDF.

Dube, Nicole, and James Orlando. 2014. “Massachusetts Health Policy Commission.” *Office of Legislative Research*. https://www.cga.ct.gov/2014/rpt/pdf/2014-R-0259.pdf.

Eibner, Christine, Peter S. Hussey, M. Susan Ridgely, and Elizabeth A. McGlynn. 2009. “Controlling Health Care Spending in Massachusetts.” RAND Corporation. https://www.rand.org/pubs/research_briefs/RB9464-1.html.

Fiedler, Matthew. 2023. “Testimony of Matthew Fiedler, Ph.D. Before the United States Senate Committee on the Budget.” United States Senate Committee on the Budget. https://www.brookings.edu/wp-content/uploads/2023/10/Fiedler-SenateBudgetTestimony-FINAL.pdf.

Foley Law Offices. 2015. “Venue Shopping: Manipulating the System or Playing by The Rules?” March 26, 2015. https://www.foleylawoffices.com/blog/venue-shopping-manipulating-the-system-or-playing-by-the-rules/.

Friedman, Gerald. 2015. “ECONOMIC ANALYSIS OF THE NEW YORK HEALTH ACT.” University of Massachusetts at Amherst. https://realitiesofsinglepayer.com/wp-content/uploads/2018/03/Economic_Analysis_New_York_Health_Act_-_GFriedman_-_April_2015.pdf.

Glickman, Aaron, and Janet Weiner. 2020. “Health Care Cost Drivers and Options for Cost Control.” Penn Leonard Davis Institute of Health Economics. https://ldi.upenn.edu/wp-content/uploads/2021/06/LDI-Issue-Brief-2020-Vol.-23-No.-4_12.pdf?_ga=2.135803697.1258469336.1695926576-1766621489.1695926576.

Gordon, Sarah H., Benjamin D. Sommers, Ira Wilson, Omar Galarraga, and Amal N. Trivedi. 2019. "The Impact of Medicaid Expansion on Continuous Enrollment: A Two-State Analysis." *Journal of General Internal Medicine* 34 (9): 1919–24. https://doi.org/10.1007/s11606-019-05101-8.

Grubs, Matt. 2023. "Doctors Warn Malpractice Changes Could Drive Providers out of New Mexico." KOB.Com, February 11, 2023. https://www.kob.com/new-mexico/4-investigates-doctors-warn-malpractice-changes-could-drive-providers-out-of-new-mexico/.

Guth, Madeline, Meghana Ammula, and Elizabeth Hinton. 2021. "Understanding the Impact of Medicaid Premiums & Cost-Sharing: Updated Evidence from the Literature and Section 1115 Waivers." KFF. 2021. https://www.kff.org/medicaid/issue-brief/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers/.

Haldar, Sweta, and Madeline Guth. 2023. "Section 1115 Waiver Watch: Continuous Eligibility Waivers and Implications for Unwinding." *KFF* (blog). April 24, 2023. https://www.kff.org/policy-watch/section-1115-waiver-watch-continuous-eligibility-waivers-and-implications-for-unwinding/.

Hitzman, Jessica. 2021. "Medicaid Management Information System Replacement (MMISR) Project Update." Human Services Department. https://www.nmlegis.gov/handouts/ALFC%20082421%20Item%209%20Medicaid%20Management%20Information%20System%20Replacement%20Update%20MMISR.PDF.

Hwang, Ann, Amy M. Lischko, Tom Betlach, and Michael H. Bailit. 2022. "State Strategies for Slowing Health Care Cost Growth in the Commercial Market." The Commonwealth Fund. https://doi.org/10.26099/m49y-2b09.

Indian Health Service. n.d. "Locations." IHS.Gov. Accessed November 15, 2023. https://www.ihs.gov/locations/.

Kurani, Nisha, and Cynthia Cox. 2020. "What Drives Health Spending in the U.S. Compared to Other Countries." *Peterson-KFF Health System Tracker* (blog). September 25, 2020. https://www.healthsystemtracker.org/brief/what-drives-health-spending-in-the-u-s-compared-to-other-countries/.

Lopez, Andy, Waldo Anton, Richard Crabtree, Frank Hesse, Seferino Montano, Moises Morales, Miles Nelson, Alicia Roman, and Michael Trujillo. 2007. "New Mexico Health Policy Commission 2006 Annual Report." New Mexico Health Policy Commission. https://www.nmhealth.org/data/view/systems/2059/.

Massachusetts Health Policy Commission. 2022. "2022 Health Care Cost Trends Report and Policy Recommendations." https://www.mass.gov/doc/2022-health-care-cost-trends-report-and-policy-recommendations/download.

Melnick, Glenn. 2022. "Health Care Cost Commissions: How Eight States Address Cost Growth." *CHCF Issue Brief*, April. https://www.chcf.org/wp-content/uploads/2022/04/HealthCareCostCommissionstatesAddressCostGrowth.pdf.

Menachemi, Nir, and Paul Halverson. 2020. “Addressing Factors That Affect Health Care Costs: Recommendations for Indiana Stakeholders.” IU Richard M. Fairbanks School of Public Health at IUPUI. https://fsph.iupui.edu/doc/research-centers/fairbanks-school-of-public-health-report.pdf.

Menachemi, Nir, Saurabh Rahurkar, Christopher A Harle, and Joshua R Vest. 2018. “The Benefits of Health Information Exchange: An Updated Systematic Review.” *Journal of the American Medical Informatics Association : JAMIA* 25 (9): 1259–65. https://doi.org/10.1093/jamia/ocy035.

Milbank Memorial Fund. n.d. “Peterson-Milbank Program for Sustainable Health Care Costs.” Milbank Memorial Fund. Accessed November 14, 2023. https://www.milbank.org/focus-areas/total-cost-of-care/peterson-milbank/.

Myall, James. 2019. “Assessing the Costs and Impacts of a State-Level Universal Health Care System in Maine.” Maine Center for Economic Policy. https://maineallcare.org/wp-content/uploads/2019/12/Assessing-the-Costs-and-Impacts-of-State-Level-Universal-Health-Care-in-Maine.pdf.

Native American Election Information Program. n.d. “23 NM Federally Recognized Tribes in NM Counties.” New Mexico Secretary of State Maggie Toulouse Oliver. Accessed November 15, 2023. https://www.sos.nm.gov/voting-and-elections/native-american-election-information-program/23-nm-federally-recognized-tribes-in-nm-counties/.

Nevola, Adrienne, Michael E. Morris, Carrie Colla, and J.Mick Tilford. 2020. “Risk-Based Contracting for High-Need Medicaid Beneficiaries: The Arkansas PASSE Program.” *Health Policy OPEN* 2 (December): 100023. https://doi.org/10.1016/j.hpopen.2020.100023.

New Mexico Human Services Department. n.d. “Health Care Authority.” Human Services Department. Accessed November 15, 2023. https://www.hsd.state.nm.us/health-care-authority/.

Norris, Louise. 2023. “Medicare in New Mexico.” Healthinsurance.Org. September 28, 2023. https://www.healthinsurance.org/medicare/new-mexico/.

Oregon Health Authority. n.d. Oregon Health Policy Board. Vol. ORS 413:006-413.017. Accessed November 10, 2023. https://www.oregon.gov/oha/hpa/pages/statutes-details.aspx?View=%7B5EB52B2E-5B03-4EDC-9356-B989638C385A%7D&SelectedID=21.

O’Reilly, Kevin B. 2022. “‘Gold Card’ Approach to Prior Authorization Introduced in Congress.” American Medical Association. July 26, 2022. https://www.ama-assn.org/practice-management/prior-authorization/gold-card-approach-prior-authorization-introduced-congress.

Pestaina, Kaye, Justin Lo, Karen Pollitz, and Rayna Wallace. 2023. “CMS Prior Authorization Proposal Aims to Streamline the Process and Improve Transparency.” *KFF* (blog). February 21, 2023. https://www.kff.org/health-reform/issue-brief/cms-prior-authorization-proposal-aims-to-streamline-the-process-and-improve-transparency/.

Peter G. Peterson Foundation. 2023. “Almost 25% of Healthcare Spending Is Considered Wasteful. Here’s Why.” April 3, 2023. https://www.pgpf.org/blog/2023/04/almost-25-percent-of-healthcare-spending-is-considered-wasteful-heres-why.

PNHP. 2019. “Connecticut Medicaid Prospers Post Capitated Managed Care.” *PNHP* (blog). 2019. https://pnhp.org/news/connecticut-medicaid-prospers-post-capitated-managed-care/.

Rakotoniaina, Adney, and Johanna Butler. 2020. “50-State Scan of State Certificate-of-Need Programs.” *NASHP* (blog). May 22, 2020. https://nashp.org/50-state-scan-of-state-certificate-of-need-programs/.

RAND Corporation. n.d. “Hospital Price Transparency Study.” Accessed November 10, 2023. https://www.rand.org/health-care/projects/price-transparency/hospital-pricing.html.

Richman, Barak D., and Kevin A. Schulman. 2023. “Healthcare Administrative Costs and Competition Policy.” *Competition Policy Antitrust Chronicle*, no. 2023–36. https://doi.org/10.1001/jama.2021.17315.

Salzbrenner, Stephen G, Carrie McAdam-Marx, Maxwell Lydiatt, Brandon Helding, Lawrence M Scheier, and Patricia Wonch Hill. 2022. “Perceptions of Prior Authorization by Use of Electronic Prior Authorization Software: A Survey of Providers in the United States.” *Journal of Managed Care & Specialty Pharmacy* 28 (10): 1121–28. https://doi.org/10.18553/jmcp.2022.28.10.1121.

Scheinker, David, Barak D. Richman, Arnold Milstein, and Kevin A. Schulman. 2021. “Reducing Administrative Costs in US Health Care: Assessing Single Payer and Its Alternatives.” *Health Services Research* 56 (4): 615–25. https://doi.org/10.1111/1475-6773.13649.

Scrase, David R., and Nicole Comeaux. 2022. “Turquoise Care Section 1115 Medicaid Demonstration Waiver Renewal Request.” New Mexico Human Services Department. https://www.medicaid.gov/sites/default/files/2022-12/nm-centennial-care-pa5.pdf.

Skoog, Derek, Julian Levin, Sam Cayemberg, Jiahui Zhou, Shubhankar Yadav, and Shreya Ahuja. 2023. “Medical Cost Trend: Behind the Numbers 2024.” PwC Research Institute. https://www.pwc.com/us/en/industries/health-industries/library/assets/pwc-behind-the-numbers-2024.pdf.

Slyter, Kirsten. 2018. “Types of Hospitals: Your Go-to Guide for Deciphering the Differences.” Rasmussen University. November 19, 2018. https://www.rasmussen.edu/degrees/health-sciences/blog/types-of-hospitals/.

Stadhouders, Niek, Florien Kruse, Marit Tanke, Xander Koolman, and Patrick Jeurissen. 2019. “Effective Healthcare Cost-Containment Policies: A Systematic Review.” *Health Policy* 123 (1): 71–79. https://doi.org/10.1016/j.healthpol.2018.10.015.

Telesford, Imani, Shameek Rakshit, Matthew McGough, Emma Wager, and Krutika Amin. 2023. “How Has U.S. Spending on Healthcare Changed over Time?” Peterson-KFF Health System Tracker. February 7, 2023. https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/.

The Commonwealth Fund. 2022. “Reduce Administrative Waste Cost Driver Targeted: Administrative Costs.” https://www.commonwealthfund.org/sites/default/files/2022-02/Hwang_health_care_cost_growth_strategy_10_administrative.pdf.

The Doctors Company. 2023. “House Bill (HB) 75 FAQs: Amendments to the New Mexico Medical Malpractice Act.” 2023. https://www.thedoctors.com/about-the-doctors-company/legislative-regulatory-and-judicial-advocacy/house-bill-hb-75-faqs-amendments-to-the-new-mexico-medical-malpractice-act/.

Turner, Ani, George Miller, and Samantha Clark. 2019. “IMPACTS OF PRIOR AUTHORIZATION ON HEALTH CARE COSTS AND QUALITY.” National Institute for Health Care Reform. https://www.nihcr.org/wp-content/uploads/Altarum-Prior-Authorization-Review-November-2019.pdf.

Turner, Ani, George Miller, and Elise Lowry. 2023. “High U.S. Health Care Spending: Where Is It All Going?” The Commonwealth Fund. October 4, 2023. https://doi.org/10.26099/r6j5-6e66.

U.S. Census Bureau. 2023. “Health Insurance Coverage Increased in Over Half of U.S. States in 2022.” Census.Gov. September 14, 2023. https://www.census.gov/newsroom/press-releases/2023/acs-health-insurance-coverage.html.

———. n.d. “My Tribal Area.” Census.Gov. Accessed November 15, 2023a. https://www.census.gov/tribal/?st=35&aianihh=1625.

———. n.d. “U.S. Census Bureau QuickFacts: New Mexico.” Census.Gov. Accessed November 15, 2023b. https://www.census.gov/quickfacts/fact/table/NM/PST045222.

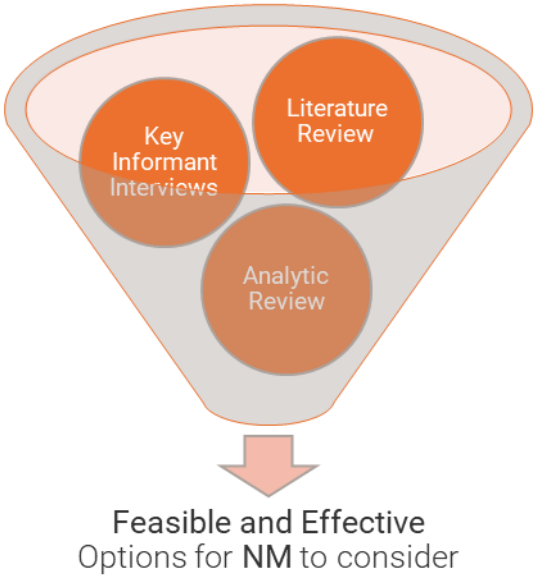
U.S. Department of Health and Human Services. n.d. “New Mexico - 2023 - III.B. Overview of the State.” HRSA Maternal & Child Health. Accessed November 15, 2023. https://mchb.tvisdata.hrsa.gov/Narratives/Overview/8b609333-f44b-4eeb-a392-f09e56afd404.

Wiener, Joshua M., Melissa Romaire, Nga (Trini) Thach, Aubrey Collins, Konny Kim, Huiling Pan, Giuseppina Chiri, et al. 2017. “Strategies to Reduce Medicaid Spending: Findings from a Literature Review.” Kaiser Family Foundation. https://files.kff.org/attachment/Issue-Brief-Strategies-to-Reduce-Medicaid-Spending-Findings-from-a-Literature-Review.

B. Methodology

To develop recommendations tailored to New Mexico's unique health care system, NORC implemented a mixed-methods approach, conducting and synthesizing the results of a literature review, key informant interviews, and an analytic review of data sources. We first conducted a literature review of proposed and implemented strategies for reducing state health care administrative costs. The results detailed the current national landscape of administrative cost reduction strategies, analyzed the effectiveness of strategies within various state systems, and informed recommendations. Next, to understand New Mexico's landscape and determine which recommendations might be most palatable and feasible for the state, we conducted interviews with key stakeholders. Finally, we completed an analytic review of several quantitative sources. Exhibit 3 visualizes the project methodology, wherein the literature review, key informant interviews, and analytic review are inputs and feasible recommendations for the state are outputs.

Exhibit 3. Overview of Project Methods



Literature Review

After selecting various search terms determined by primary search terms (e.g., "health care," "administrative," and "cost reduction") and secondary search terms (e.g., "spending reduction," "burden," "overhead"), NORC conducted a literature review to identify expert policy recommendations for reducing health care administrative costs. NORC then searched several databases, including Google, Google Scholar, PubMed Central, and PubMed for relevant websites, government documents, and peer-reviewed literature. Articles were selected based on inclusion and exclusion criteria. We identified additional sources through the references cited by previously selected and excluded articles and sought out other articles to further explore new ideas posed by stakeholders or to provide context.

Please see the appendix for the full Literature Review Protocol as well as the Additional Findings Table, which provides a comprehensive list of strategies identified in the literature.

Key Informant Interviews

Strategy

From September 2023 to October 2023, NORC conducted 19 semi-structured Zoom interviews with key stakeholders who represent New Mexico hospitals, government agencies, insurance plans, membership associations, and digital infrastructure companies (See Appendix G). To identify representatives from multiple areas of health care to provide insight from a variety of diverse perspectives, our consultant, Beth Landon, conducted outreach efforts to potential interviewees. Additional stakeholders were identified through contacts recommended by previously selected interviewees.

Interviews

In collaboration with Beth Landon, we developed an interview strategy to ensure that we obtained feedback on potential administrative cost reduction methods from a diverse set of stakeholders in the New Mexico health care system. Findings from our research environmental scan were used to develop the interview protocol and interview questions. Based on stakeholders' responses to the initial question—regarding their top opportunities for reducing health care administrative costs—we then followed up about specific approaches, including technological strategies, reimbursement strategies, claims and billing processes, clinical strategies, measurement-based strategies, contractual strategies, and eligibility and benefits verification. Beth Landon and NORC Principal Research Director Rebecca Catterson conducted the interviews, which were recorded after obtaining consent from participants. See Appendix G for a complete list of all stakeholders interviewed.

Analysis

We performed our analysis using NVivo, a qualitative data analysis software, to identify themes across interviews. We developed a list of topical codes based on the moderator guides for the interviews. Members of the research team then coded each transcript, tagging and organizing content into the codes. After content was coded, NORC researchers conducted a thematic analysis of the content within each topical code to identify themes (e.g., strategies mentioned by multiple participants and compelling quotations illustrating the identified themes). Findings are can be found in the recommendations section. Exhibit 4 provides a complete list of the codes.

Exhibit 4. NVivo Codebook

Parent Code	Associated Child Codes
Priority or top of mind	N/A
Claims and billing processes	• Standardization of requirements, forms, processes • Automation of claims procedures • Centralized clearinghouse
Clinical strategies	• Reforming prior authorization/continuing authorization • Eliminate payment for adverse hospital events • Complex care management/chronic disease management • Patient-centered medical homes (PCMH) • Reduce low-value care • Increase use of hospice or end-of-life care
Eligibility and benefits verification	• Add premiums or out-of-pocket costs to Medicaid • Administrative renewal • Continuous enrollment
Reimbursement strategies	• Single payer • Bundled payments for episodes—standardized across MCOs • Price regulation—growth caps, benchmarking, price caps processes • Eliminating Medicaid MCOs • APMs or capitated models
Technological strategies	• APCDs—use for price transparency • HIE or compatible platforms between organizations or common digital infrastructure or same EHR • Bridge between clinical and administrative data
Workforce & automation strategies	• Automate administrative workflows
Measurement-based strategies	• Harmonizing quality metrics among payers • Limit use of performance measures • Facilitate automated data collection and quality-measure reporting
Contractual and legal strategies	• Model contract structures so that prior authorization and claim adjudication are the same across contracts • Medical liability reform • Mergers & acquisitions
Other	• Continue many COVID-era administrative relaxations • Use narrow or tiered networks

Parent Code	Associated Child Codes
	• Other
Great quotes	N/A

Analytic Review

To understand administrative costs, total revenue, and payments to executive officers, we reviewed hospital cost report forms from HCRIS, IRS 990 forms from the IRS webpage, and various rule-making files from the CMS website. We cleaned the data in Excel and performed analyses in R, an analytic and statistical software, based on the type of data collected. Exhibit 5 contains the questions we sought to answer in the analytic review. For further methodologic information and the results of the analytic review, please see Appendix H.

Exhibit 5. Data Sources Reviewed and Questions Answered

Data Source	Questions
Hospital costs reports	1. What proportion of hospital costs are attributable to administrative costs? 2. How does this differ by hospital? How have administrative costs changed over time? 3. How do NM hospitals compare to similar hospitals across the country? 4. How do administrative cost burdens relate to various observable attributes of hospital cost structure (e.g., payer mix, revenue efficiency/margin)? Are NM hospitals odd in any particular regard? Are uncompensated care costs related to administrative costs?
IRS 990 forms	1. To the extent observable, what proportion of hospital revenues are paid out to board officers and executives? 2. To the extent observable, what proportion of revenues are spent on charitable community programs, such as meals?
Various-rulemaking files	1. What proportion of government payments to providers are due to administrative costs? 2. What changes can have substantial impacts on administrative cost reduction?

Recommendations

Finally, we synthesized results from the literature review, key informant interviews, and analytic review to develop feasible recommendations for the state of New Mexico to consider in developing legislation and rules to reduce administrative health care costs. Further information on our process for developing recommendations can be found in the “Findings and Recommendations” section of the full report.

C. Options Considered but Not Recommended

We examined several other administrative cost reduction strategies that we have decided not to recommend. Many of them are worthwhile recommendations for clinical quality or access to care but are unlikely to reduce administrative costs. Appendix D includes a table of additional findings from the literature with references to all articles reviewed, by recommendation. Others have the potential to reduce administrative costs but have very high upfront costs and implementation hurdles that make them less reasonable options for the state.

Clinical Reforms Such as Care Management, PCMH, Reducing Low-Value Care: NOT Recommended

Clinical reforms such as care management, patient-centered medical homes (PCMHs), and reducing low-value care have limited evidence for their ability to reduce administrative costs. These initiatives may be considered from a clinical policy-making perspective, but we do not recommend considering them as methods to reduce administrative costs, as they are unlikely to have a significant impact on administrative burden.

Several articles that evaluated complex care management strategies for their potential to reduce administrative burden found poor to mixed results. One study estimated that integrated behavioral and physical health services could produce significant savings by increasing provider collaboration (Peter G. Peterson Foundation 2023), but evaluations of a commercially insured population (Hwang et al. 2022) and the Arkansas Provider-Led Shared Savings Entity (PASSE) program for high-need Medicaid beneficiaries (Nevola et al. 2020) did not show savings and may have increased administrative burden. Results from the very few evaluations are mixed. One article suggests that care coordination reduces health care costs in general (Stadhouders et al. 2019). One article found that medical homes “do not appear likely to yield substantial savings” (Eibner et al. 2009), while another found significant savings in PCMH programs vs. traditional primary care (Crowley et al. 2020).

A few articles suggest reducing low-value care as an option for lowering health care costs, by achieving administrative efficiencies via billing and processing claims for fewer unnecessary procedures. Methods for reducing low-value care include increasing clinician awareness of low-value service usage, using EHRs to provide clinical decision support, education and decision aids, patient cost-sharing, and increasing the use of palliative care. However, stakeholders from the provider’s side argued that low-value care is a misnomer and that clinicians should be able to recommend the tests and procedures they feel are necessary. Stakeholders also noted that the clinical strategy that was most likely to reduce administrative costs was prevention or “spending more time maintaining health” and having “engagement with members and patients.” Administrative cost reduction has the potential to be a byproduct of some clinical reforms, but we recommend that they be considered from a quality-of-care perspective rather than an administrative-burden perspective.

Medicaid Policy Reforms: Additional Changes to Eligibility—NOT Recommended

Changes to Medicaid eligibility practices such as continuous enrollment or administrative renewals have not been found to be a significant source of administrative cost reduction. Although New Mexico may consider these policies for other reasons, including quality of care and increased access, we do not recommend that the state look at these reforms as potential sources of reduced administrative burden.

There is some evidence of administrative cost reduction in the literature, as implementing administrative renewal was found to reduce administrative costs by lowering the number of manual Medicaid redeterminations required. One article found value using administrative renewal for beneficiary groups with an 80 percent or greater likelihood of eligibility (Dorn and Buettgens 2013). Administrative expenses may also be reduced by adopting continuous enrollment through an 1115 waiver due to decreased costs associated with eligibility renewals (Gordon et al. 2019). However, there are upfront costs associated with changes in eligibility, and stakeholders noted that changes in eligibility may have unexpected impacts on overall health care costs.

Stakeholders noted that New Mexico already has a system of administrative renewals for some populations, wherein "they have to proactively report a change to us. We don't go looking for data to see if they're not eligible." One stakeholder noted that "CMS would not give us 100% federal financial participation for continuous eligibility" back when New Mexico implemented the Affordable Care Act and stated that "we haven't since then really revisited it, because we don't see a ton of churn with that population." New Mexico has a pending 1115 waiver to provide continuous eligibility for children through age five (Haldar and Guth 2023). Depending on how this policy impacts Medicaid spending and administrative costs, New Mexico may want to consider a similar policy for adults in the future, once the potential impacts are better understood.

Medicaid Policy Reforms: Eliminating Medicaid MCOs—NOT Recommended

Although there has been evidence of administrative savings after Connecticut eliminated Medicaid MCOs, there is a massive upfront cost to bring all administrative functions under the state. Stakeholders do not seem to have the appetite for undertaking such a drastic change. In addition, there are also significant flexibilities, particularly in rate setting, to consider, and as of now, New Mexico relies on these flexibilities for Medicaid funding. If New Mexico wanted to eliminate MCOs, we would recommend first undertaking an analysis of the financial impacts such a change would have on the state. The, the change would involve a multiyear process wherein the state would build capacity to take on these functions over time. Even then, it is important to note, it may take many years to see appreciable administrative savings after a massive upfront investment.

From the literature, a few sources introduced the idea of eliminating MCOs and switching to fee-for-service (FFS) for the state Medicaid programs. Experts have strong opinions, ranging from wide support to strong disapproval. Connecticut is the only state that has eliminated MCOs and transferred all Medicaid services to an FFS model. Evaluations of the change show that Connecticut's member per-

month costs have decreased 14 percent since the switch and that only 3.5 cents per dollar spent on Medicaid are going toward administrative costs (PNHP 2019).

Despite Connecticut's success, stakeholders were cautious about considering such a change. They noted that "it would be a very, very difficult transition to get that function completely back to the state." One stakeholder clearly stated "my concern is that the perception that managed care is really expensive does not take into account the administrative effort that the agency would have to take on ... because, instead of being like 1 one hundredth of a percent of our budget, suddenly our administrative expenses will go through the roof because we would have to be managing fee-for-service plans for almost a million people." Others noted that "the Medicaid MCOs actually are a really important source of financing for the State" due to premium taxes and an assessment. One stakeholder explained that "there's a perception that there are a lot of opportunities for cost savings" by getting rid of managed care or making them "run even leaner," but that "frankly, they're running pretty lean at this point." Another explained that the state would be putting federal money at risk because under managed care, Medicaid upper payment limits can go as high as the average commercial rate.

However, stakeholders also shared criticisms of MCOs. One noted that instead of "managing care" all they see is "administrative barriers." Another stated that "MCOs don't have any incentive to make anything simple," and one said, "we're heading in the wrong direction as a state by adding more Medicaid managed care companies to our system." Instead of eliminating MCOs, some stakeholders offered alternatives, such as "a really vigorous and accountable state role in managing the MCOs," including "accountability for any complaints of grievances that providers raise." Another noted the importance of directed payments in holding MCOs accountable, noting that "you can literally, as the term suggests, direct the MCOs to pay a certain amount to the hospital so they can't pocket a difference between their negotiated rate and the directed payment." Although MCOs are not highly popular in New Mexico, most stakeholders agreed that it would be more reasonable to increase the state's management and accountability over the MCOs rather than trying to eliminate them altogether.

Medicaid Policy Reforms: Cost Sharing—NOT Recommended

Implementing cost sharing, such as premiums or coinsurance, for Medicaid beneficiaries, is not a method we would recommend for reducing administrative costs. Although this recommendation comes up in the literature, most findings point to its increasing administrative costs and reducing access to care.

Although some articles recommend cost sharing for Medicaid beneficiaries, the limited evaluations of cost sharing do not show benefits. One study found "limited state savings from premiums and cost sharing," as any efficiencies were offset but increased average medical claim costs (Guth et al. 2021).

Narrow or Tiered Networks—NOT Recommended

Narrow or tiered networks have been shown to reduce costs in states with multiple health plans/MCOs. However, in small rural states like New Mexico, most health plans need to include all local providers in

their networks to meet member needs. New Mexico is already a narrow network, so we do not recommend this method for cost reduction.

Multiple studies show narrow or tiered provider networks are associated with lower costs; however, there are concerns that narrow or tiered networks can lead to delays in receiving appropriate care, limited access for patients in rural areas, high out-of-pocket expenses and higher bills, and potential reduction in quality of treatment (Menachemi and Halverson 2020). Stakeholders noted that New Mexico is already a "narrow network," stating that outside of Albuquerque and Las Cruces, it would be "surprising" if a provider is paneled with Medicaid and not with all the carriers.

Implementing a Uniform EHR for All Hospitals—NOT Recommended

Early in our interviews, some stakeholders recommended that the state could support, via funding and technical assistance, moving all hospitals to the same EHR. Although we do recommend an interoperable system, the expenses involved in moving all hospitals to the same EHR would be significant. The state has invested considerable funds in developing an HIE (SYNCRONYS), which can serve a similar purpose by allowing for data sharing across providers, policy-makers, and payers. Having a fully operational and useful HIE would be a more efficient way to increase interoperability than funding EHR changes for hospitals, so we are not recommending a uniform EHR.

Researchers examined the use of a certified EHR at a large academic health care system and "found no evidence that adoption of these expensive EHR systems reduced billing costs related to physician services" (Davis 2018). They concluded that high costs associated with EHRs "are the consequences of heterogeneous payment requirements across the multiple payers and health plans contracting with the academic health center" (Davis 2018). Even if hospitals achieved interoperability by using a uniform EHR, there would still be high administrative costs associated with different policies, requirements, and contracts across payers/health plans.

Although stakeholders were concerned about interoperability and were hopeful that an HIE (SYNCRONYS) would be able to meet the need for an interoperable IT system, most were hesitant about moving to a uniform EHR. One stakeholder said, "I cannot imagine telling the entire hospital staff, 'Great news. We are simplifying the EMR world, and we are all switching to Epic. It is a little $1 billion investment, and it is going to make our lives so much better.' How many 60-year-old physicians are going to walk?" Another believed that no matter which EHR is used "people don't like it because it's too hard to use and it's too complicated" and stated that a universal EHR does not seem like a "realistic" solution to the problem of interoperability.

Certificate of Need Programs—NOT Recommended

A certificate of need (CON) program is a "state regulatory tool that controls the number of health care resources in an area" by requiring "a hospital or health system to demonstrate community need before establishing or expanding a health care facility or service" (Rakotoniaina and Butler 2020). Although

CON programs can give states an opportunity to halt hospital expansions that may not be necessary or may harm other hospitals, we do not recommend developing a CON law in New Mexico.

There is evidence that CON programs actually increase health care costs and have a negative impact on quality measures (Berenson et al. 2020; Conover and Bailey 2020). Rather than requiring a CON, New Mexico could consider other methods of overseeing hospital growth such as cost growth caps (see **Recommendation 8**).

Bundled Payments, Other APMs as a Tool for Administrative Cost Reduction—NOT Recommended

Numerous sources recommend variations on alternative payment models (APMs) to reduce administrative cost burden, with bundled payments being the most frequently cited method. However, the evidence is limited regarding whether such models can reduce administrative costs, and they may actually increase costs by being separate programs. APMs may be useful in other ways, such as promoting quality and standardizing costs among populations, but they are unlikely to have a significant impact on administrative costs. Therefore, we would not recommend pursuing APMs for the purpose of administrative cost management; rather they should be considered, as a strategy for improving quality, access, and patient outcomes, with the understanding that they may increase administrative costs.

Bundled payments could reduce administrative complexity for both providers and payers by limiting the number of claims submitted for a condition, however, evidence on their ability to contain Medicaid costs is "very limited" (Wiener et al. 2017) and savings may be likely "only for a small portion of the population" (Eibner et al. 2009). Stakeholders noted that APMs are "actually a bit more of an admin burden" as organizations need to invest the "time and infrastructure to build [them] out in a thoughtful way." One stakeholder said that New Mexico does not have enough patient volume to make many APMs worthwhile. Bundled payments were similarly viewed with hesitation. One stakeholder noted that "bundling is [often] a mechanism for paying hospitals less." In the right situation, stakeholders believed that capitation could work very well, such as in communities with "a close-knit system" and enough capacity to make sure "that everybody gets a share of that capitated payment."

Single-Payer Health Care System—NOT Recommended

Since there is a low privately insured population in New Mexico, it is likely not possible for a state-based single-payer health care system to work currently. Because Medicaid, Medicare, Tricare, and some other groups would probably not be included in the single-payer mix, that would leave a proportionately small population to support the costs of administering the program. The state would also incur significant startup costs involved in taking over administration of programs. A single-payer health insurance system would reduce administrative costs at a national level, but states must contend with a multipayer system and, without significant changes to federal policy, would not be able to reap the benefits of single payer. Therefore, we do not recommend a single-payer system as an avenue for reducing administrative costs at the state level.

Several articles noted that a single-payer health care system would significantly reduce administrative costs. In addition, two-tier, insurance-mandate-based, or multipayer systems can perform as well as a single-payer system from an administrative perspective—if there is government control over prices and administrative processes (Scheinker et al. 2021). Moreover, there are significant barriers to implementing a single-payer system anywhere in the United States, including political will, negative public opinion, concern over tax increases and lower provider remuneration, and the note that "there has not even been government approval for a demonstration project to test single payer in the U.S." (Cai et al. 2020).

All state single-payer system proposals and overviews that we reviewed assumed that the "federal government will agree to continue funding ACA subsidies, Medicaid, and other federal health programs at current rates," despite the state's implementing a single-payer system (Friedman 2015). However, some researchers are critical of this assumption. One states that "it is unlikely that the federal government would cede its authority over these programs and their associated funding to any state government" (Myall 2019). Another posits that redirecting federal funds would require federal permissions and statutory changes to both Medicare and Medicaid law (Bindman et al. 2018).

Stakeholders were generally dismissive of a state single-payer system, noting that "it seems it could be problematic." In general, there does not seem to be much belief that a single-payer system could work and be financially viable in New Mexico at this time. Because a move to a single-payer health care system would take significant time, effort, and resources, stakeholder support would be crucial before considering pursuing it.

D. Additional Findings from Literature Review

Exhibit 6. Administrative Cost Reduction Methods by Source, from Literature Review

	Recommendation	Evidence
Claims and Billing Processes	Electronic transactions/block chains for data transfer	Appold (2019), Center for Health Care Purchasing Improvement (n.d.), Council for Affordable Quality Healthcare (2022), Department of Financial Services (2021), Office for Oregon Health Policy and Research (2010)
	Centralized claims processing (e.g., automatic clearinghouse)	Cutler (2020b), Center for Health Care Purchasing Improvement (n.d.), Fiedler (2023), Galvani et al. (2020), Gee & Spiro (2019), Keating & Ewing-Nelson (2022), Peter G. Peterson Foundation (2023a), The Commonwealth Fund (2022), Sahini et al. (2021)
	Standardization and automation of claims procedures	Center for Health Care Purchasing Improvement (n.d.), Department of Financial Services (2021), Gee & Spiro (2019), Peter G. Peterson Foundation (2023a), Sahini et al. (2021)
	Standard set of payment rules or requirements	Culter (2020a), Fiedler (2023), Gee & Spiro (2019), Guzick (2020), Quincy & Staren (2018)
	Standard payment/billing forms	Blake et al. (2019), Department of Financial Services (2021), Gee & Spiro (2019), The Commonwealth Fund (2022)
	Automate repetitive work in HR/finance	Peter G. Peterson Foundation (2023a), Sahini et al. (2021)
Prior Authorization Reform	Standardization of prior authorization procedures	Blake et al. (2019), Cutler (2018), Quincy & Staren (2018)
	Standardization of services covered by prior authorizations	AAFP (2023), Turner et al. (2019)
	Standardization of the prior authorization submission process	Crespi-Lofton (2020), Turner et al. (2019)

	Recommendation	Evidence
	Using compatible criteria for prior authorizations	Peter G. Peterson Foundation (2023a), Quincy & Staren (2018), Sahini et al. (2021)
	Pharmacist-initiated prior authorizations	Crespi-Lofton (2020)
	Fully electronic prior authorization system	American Medical Association et al. (2018), Council for Affordable Quality Healthcare (2022), Crespi-Lofton (2020), Keating & Ewing-Nelson (2022), Pestaina et al. (2023), Quincy & Staren (2018), Salzbrenner et al. (2022), The Commonwealth Fund (2022), Turner et al. (2019)
	Automation of prior authorizations	American Medical Association et al. (2018), The Commonwealth Fund (2022), Turner et al. (2019)
	Provider process improvements, including the use of pharmacy technicians for prior authorizations and centralized PA teams	Blake et al. (2019), Crespi-Lofton (2020), Cutler (2018), Turner et al. (2019)
	Strategic application, simplification, and/or reduction of prior authorizations	American Medical Association et al. (2018), Crespi-Lofton (2020), Cutler (2020b), Department of Financial Services (2021), Keating & Ewing-Nelson (2022), Sinsky & Linzer (2020), The Commonwealth Fund (2022), Turner et al. (2019)
	Sunset and Gold Card Programs	Crespi-Lofton (2020), Cutler (2020b), The Commonwealth Fund (2022), Turner et al. (2019)
	Requiring “fast turnaround (within 48 hours) of prior authorization requests”	The Commonwealth Fund (2022)
	Increasing the transparency of clinical review criteria	American Medical Association et al. (2018), Department of Financial Services (2021)
Clinical Strategies	Palliative care in hospitals	Crowley et al. (2020), Menachemi & Halverson (2020)

	Recommendation	Evidence
	Complex care management and chronic disease management	Howerton (2021), Hwang et al. (2022),** National Conference of State Legislatures (2023), Nevola et al. (2020),** Wiener et al. (2017),* Willging et al. (2014)**
	Health homes	National Conference of State Legislatures (2023), Wiener et al. (2017)*
	Disease prevention	Crowley et al. (2020), Eibner et al. (2009),* Peter G. Peterson Foundation (2023a)
	Care coordination	National Conference of State Legislatures (2023), Nevola et al. (2020),** Peter G. Peterson Foundation (2023a), Peter G. Peterson Foundation (2023b), Stadhouders et al. (2019)
	Eliminate payment for adverse hospital events	Eibner et al. (2009), Peter G. Peterson Foundation (2023a)
	Enrollee wellness incentives	Government Finance Officers Association (2014), National Conference of State Legislatures (2023), Wiener et al. (2017)*
	Expanding home and community-based services (HCBS)	Howerton (2021), National Conference of State Legislatures (2023), Wiener et al. (2017)*
	Increasing use of managed long-term services and supports (LTSS)	National Conference of State Legislatures (2023), Wiener et al. (2017)*
	PCMH	Crowley et al. (2020), Eibner et al. (2009),** National Conference of State Legislatures (2023), Wiener et al. (2017)*
	Reducing low value care[8]	Budros et al. (2020), Chernew et al. (2021), CIVHC (2020), Crowley et al. (2020), Government Finance Officers Association (2014), Massachusetts Health Policy Commission (2021), Massachusetts Health Policy Commission (2022), Menachemi & Halverson (2020), OECD (2017), Peter G. Peterson Foundation (2023a), Peter G. Peterson Foundation (2023b), Stadhouders et al. (2019)

	Recommendation	Evidence
	Emphasizing high value care in designing essential benefits packages	Crowley et al. (2020), Government Finance Officers Association (2014)
	Increasing the use of hospice/end of life care	Menachemi & Halverson (2020)
	Coverage related to SDOH	Massachusetts Health Policy Commission (2021), Massachusetts Health Policy Commission (2022), Health and Human Services Commission (2021)
	Reduce severity adjustments for payments (e.g., paying more for an ED visit or hospitalization for someone with more chronic conditions)	Cutler (2018)
Automation and Technological Strategies	All-Payer Claims Database (APCD)	Berenson et al. (2020), Budros et al. (2020), Crowley et al. (2020), Guzick (2020), Menachemi & Halverson (2020), National Conference of State Legislatures (2023), RAND Corporation (n.d.)
	Compatible platforms between organizations (“common digital infrastructure”)	Peter G. Peterson Foundation (2023a), OECD (2017), Richman & Schulman (2023)
	Common data standards/Health Information Exchanges (HIE)	Congressional Budget Office (2022), Culter (2020b), Gee & Spiro (2019), Menachemi et al. (2018), Quincy & Staren (2018)
	“Harmonizing quality metrics” across payers	Chigurupati & Kocher (2021), Congressional Budget Office (2022), Crowley et al. (2020), Cutler (2020b), Fiedler (2023), Keating & Ewing-Nelson (2022), Kocher & Chigurupati (2021), Quincy & Staren (2018), The Commonwealth Fund (2022)
	Uniform EHR	Davis (2018),** Gee & Spiro (2019), Holland (2018),** OECD (2017), Sinsky & Linzer (2020)
	Integrating measures into EHRs	Davis (2018),** Gee & Spiro (2019), Holland (2018),** OECD (2017)

	Recommendation	Evidence
	Using HIEs to produce measures	Health and Human Services Commission (2021)
	Software to monitor hospital admissions	Shi (2023)
	Blockchains to manage EHR	Vazirani et al. (2019)
	Interoperability to build a bridge between clinical and administrative data	Culter (2020b), Council for Quality Affordable Healthcare (2022)
	Meaningful measures	Cutler (2020b), Sinsky & Linzer (2020)
	Limit the use of performance measures	Porter (2019)
	Facilitate automated data collection and quality measure reporting	Culter (2018), Office for Oregon Health Policy and Research (2010), Porter (2019), Quincy & Staren (2018)
	Access to electronic medical records	Department of Financial Services (2021), OECD (2017)
	Leveraging analytics and technology	Appold (2019), Ario et al. (2019), Chigurupati & Kocher (2021), Kocher & Chigurupati (2021), Massachusetts Health Policy Commission (2022), Menachemi & Halverson (2020), Peter G. Peterson Foundation (2023a), Sahini et al. (2021), Shi (2023), Sinsky & Linzer (2020)
Workforce/Automation Strategies	Automate administrative workflows	Appold (2019), Cutler (2018), Council for Affordable Quality Healthcare (2022), Kocher & Chigurupati (2021), Sahini et al. (2021)
	Use Artificial Intelligence to support EHR	CODE (n.d.)

	Recommendation	Evidence
Payment Policy, Reimbursement, and Operational Strategies	Single payer system	Bindman et al. (2018), Bivens (2018), Blumberg & Holahan (2019), Cai et al. (2020), El-Sayed (n.d.), Friedman (2015), Galvani et al. (2020), Himmelstein & Woolhandler (2020), Jiwani et al. (2019), Myall (2019), Quincy & Staren (2018), Scheinker et al. (2021), Yu & Zhang (2017)[9]
	Alternative payment models (APMs)	Chernew et al. (2021), Chernew & Mintz (2021),** Chigurupati & Kocher (2021), Deffarges (2020), Eibner et al. (2009),* Gee & Spiro (2019), Government Finance Officers Association (2014), Himmelstein & Woolhandler (2020),** Hwang et al. (2023), Massachusetts Health Policy Commission (2021), Massachusetts Health Policy Commission (2022), Menachemi & Halverson (2020), Nevola et al (2020),** Sahini et al. (2021), Waters & Karpf (2020)
	Bundled payments	Appold (2019), Eibner et al. (2009),* Holland (2018), Menachemi & Halverson (2020), National Conference of State Legislatures (2023), Wiener et al. (2017)*
	Pay-for-Quality models	Health and Human Services Commission (2021)
	Accountable Care Organizations (limited evidence)	National Conference of State Legislatures (2023), Wiener et al. (2017)*
	Models with risk adjustment and quality bonus payments	Douven et al. (2022),** Waters & Karpf (2020)
	Population-based provider payments	Hwang et al. (2022)
	Shared Savings Partnerships (ACOs)—standardize models	Nevola et al. (2020)**

	Recommendation	Evidence
	Price regulation[10]	Ario et al. (2019), Bivens (2018), Berenson et al. (2020), Chernew et al. (2021), Chernew & Mintz (2021),** Crowley et al. (2020), Cutler (2020a), Eibner et al. (2009), Galvani et al. (2020), Hatzenbeller (2022), Hwang et al. (2023), Hwang et al. (2022), Hyman (2018), Massachusetts Health Policy Commission (2021), Massachusetts Health Policy Commission (2022), Menachemi & Halverson (2020), Pany et al. (2022), Peter G. Peterson Foundation (2023a), Quincy & Staren (2018), Stadhouders et al. (2019)
Medicaid Policy and Eligibility and Benefits Verification	Administrative renewal	Dorn & Buettgens (2013)
	Adding premiums/OOP Costs to Medicaid	Guth et al. (2021),* National Conference of State Legislatures (2023), Wiener et al. (2017)**
	Tightening eligibility for LTSS	Wiener et al. (2017)**
	Eligibility verifications through a standard electronic system[11]	Center for Health Care Purchasing Improvement (n.d.), Council for Quality Affordable Healthcare (2022), Gordon et al. (2019), Office for Oregon Health Policy and Research (2010), U.S. Government Accountability Office (2021)
	Continuous enrollment (adults)	Gordon et al. (2019)
	Expanding Medicaid Eligibility[12]	Bivens (2018), Deffarges (2020), National Conference of State Legislatures (2023),
	Eliminating Managed Care Organizations (MCO) and switching to Fee-For-Service (FFS)	Burns (2023), PNHP (2019), Stadhouders et al. (2019)*
	Restricting Medicaid eligibility	National Conference of State Legislatures (2023)
	Cost-sharing for Medicaid beneficiaries	Guth et al. (2021),** National Conference of State Legislatures (2023), Stadhouders et al. (2019), Wiener et al. (2017)**

	Recommendation	Evidence
	Sharing insurance coverage information with providers electronically	Department of Financial Services (2021), Sahini et al. (2021)
	Narrow or tiered provider networks	Chernew et al. (2021), Menachemi & Halverson (2020)**
Medical Liability Reform and Contractual/Legal Strategies	Medical liability reform	Crowley et al. (2020)
	Standardizing physician licensure (and medical policies)	Peter G. Peterson Foundation (2023a), Quincy & Staren (2018), Sahini et al. (2021)
	Simplifying or standardizing credentialing for providers	Department of Financial Services (2021), Keating & Ewing-Nelson (2022)
	Use of antitrust laws to prevent consolidation from driving up prices; monitor provider consolidation	Berenson et al. (2020), Bivens (2018), Chernew et al. (2021), Crowley et al. (2020), Hatzenbeler (2022), Hwang et al. (2022)
	Model contract structures/contract simplification	Chigurupati & Kocher (2021),Scheinker et al. (2021)
Other	Promoting private long-term care insurance	Wiener et al. (2017)**
	Consumer protection, limiting debt collecting from non-transparent hospitals	Hatzenbeler (2022)
	Continue many COVID-era administrative relaxations	Massachusetts Health Policy Commission (2022), Sinsky & Linzer (2020)
	Eliminate certificate of need laws for capital improvements	Berenson et al. (2020), Conover & Bailey (2020)
	Oversight of health insurance review rate	Berenson et al. (2020), Hwang et al. (2022)

	Recommendation	Evidence
	Stricter requirements for real-time adjudication of prior authorization and auto-adjudication of claims	Chigurupati & Kocher (2021)
	Establishing a state commission to "monitor and control health care cost growth"	Melnick (2022)

Key
*Indicates a lack of evidence in support of a strategy, or mixed evidence **Indicates evidence against a strategy

References for Appendix D

AAFP. 2023. “Prior Authorization and Step Therapy (Position Paper).” October 2023. https://www.aafp.org/about/policies/all/prior-authorizations.html.

American Medical Association, American Hospital Association, America’s Health Insurance Plans, Blue Cross Blue Shield Association, Medical Group Management Association, and American Pharmacists Association. 2018. “Consensus Statement on Improving the Prior Authorization Process.” American Medical Association. https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf.

Appold, Karen. 2019. “Eight Ways to Reduce Healthcare Administrative Costs,” Managed Healthcare Executive October 2019 Issue, 29 (October). https://www.managedhealthcareexecutive.com/view/eight-ways-reduce-healthcare-administrative-costs.

Ario, Joel, Kevin McAvey, and Kyla Ellis. 2019. “Implementing a Statewide Healthcare Cost Benchmark:” Manatt Health. https://www.oregon.gov/oha/HPA/HP/HCCGBDocs/RWJ-Phase-5-Report-Cost-Benchmarking-Paper-December-2019.pdf.

Berenson, Robert A, Jaime S King, Katherine L Gudiksen, Roslyn Murray, and Adele Shartzer. 2020. “Addressing Health Care Market Consolidation and High Prices.” https://www.urban.org/sites/default/files/publication/101508/addressing_health_care_market_consolidation_and_high_prices_1.pdf.

Bindman, Andrew, Marian Mulkey, and Richard Kronick. 2018. “A Path to Universal Coverage and Unified Health Care Financing In California.” University of California, San Francisco. https://healthcare.assembly.ca.gov/sites/healthcare.assembly.ca.gov/files/Report%20Final%203_13_18.pdf.

Bivens, Josh. 2018. “The Unfinished Business of Health Reform.” Economic Policy Institute. https://files.epi.org/pdf/152676.pdf.

Blake, Sarah C., Minna Song, Laura Gaydos, and Janet R. Cummings. 2019. “Prior Authorization Policies and Preferred Drug Lists in Medicaid Plans: Stakeholder Perspectives on the Implications for Youth with ADHD.” *Administration and Policy in Mental Health* 46 (5): 580–95. https://doi.org/10.1007/s10488-019-00937-y.

Blumberg, Linda J., and John Holahan. 2019. “The Pros and Cons of Single-Payer Health Plans.” Urban Institute. https://www.urban.org/sites/default/files/publication/99918/pros_and_cons_of_a_single-payer_plan.pdf.

Budros, Michael, Michael Chernew, and A. Mark Fendrick. 2020. “Utilization and Spending on Low-Value Medical Care Across Four States.” V-BID Health. https://vbidhealth.com/docs/APCD-LVC-Final.pdf.

Burns, Joseph. 2023. “Connecticut Bucks the Medicaid Managed Care Trend,” MHE January 2023, 33 (January). https://www.managedhealthcareexecutive.com/view/connecticut-bucks-the-medicaid-managed-care-trend.

Cai, Christopher, Jackson Runte, Isabel Ostrer, Kacey Berry, Ninez Ponce, Michael Rodriguez, Stefano Bertozzi, Justin S. White, and James G. Kahn. 2020. “Projected Costs of Single-Payer Healthcare Financing in the United States: A Systematic Review of Economic Analyses.” *PLoS Medicine* 17 (1): e1003013. https://doi.org/10.1371/journal.pmed.1003013.

Center for Health Care Purchasing Improvement. n.d. “Minnesota’s Health Care Administrative Simplification Initiative.” Minnesota Department of Health. https://www.health.state.mn.us/facilities/ehealth/asa/docs/factsheetadminsimp.pdf.

Chernew, Michael E., David M. Cutler, and Shivani A. Shah. 2021. “Reducing Health Care Spending: What Tools Can States Leverage?” The Commonwealth Fund. 2021. https://www.commonwealthfund.org/publications/fund-reports/2021/aug/reducing-health-care-spending-what-tools-can-states-leverage.

Chernew, Michael, and Harrison Mintz. 2021. “Administrative Expenses in the US Health Care System: Why So High?” *JAMA* 326 (17): 1679–80. https://doi.org/doi:10.1001/jama.2021.17318.

Chigurupati, Anuraag, and Bob Kocher. 2021. “Challenges and Opportunities for Administrative Simplification in US Health Care.” *Health Services Research* 56 (4): 578–80. https://doi.org/10.1111/1475-6773.13692.

CIVHC. 2020. “Low Value Care in Colorado.” Center for Improving Value in Health Care. https://www.civhc.org/wp-content/uploads/2020/03/Low-Value-Care-Public-Report_FINAL.pdf.

CODE. n.d. “How Can AI Applications in Healthcare Reduce Costs and Administrative Burdens?” CODE. https://healthdatasharing.org/q-and-a/how-can-ai-applications-in-healthcare-reduce-costs-and-administrative-burdens/.

Congressional Budget Office. 2022. “Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals’ and Physicians’ Services.” 2022. https://www.cbo.gov/publication/58541.

Conover, Christopher J., and James Bailey. 2020. “Certificate of Need Laws: A Systematic Review and Cost-Effectiveness Analysis.” *BMC Health Services Research* 20 (August): 748. https://doi.org/10.1186/s12913-020-05563-1.

Council for Affordable Quality Healthcare. 2022. “2021 CAQH Index Working Together: Advances in Automation During Unprecedented Times.” CAQH. https://www.caqh.org/sites/default/files/explorations/index/2021-caqh-index.pdf.

Crespi-Lofton, Judy. 2020. “AMCP Partnership Forum: Optimizing Prior Authorization for Appropriate Medication Selection.” *Journal of Managed Care & Specialty Pharmacy* 26 (1): 10.18553/jmcp.2020.26.1.55. https://doi.org/10.18553/jmcp.2020.26.1.55.

Crowley, Ryan, Hilary Daniel, Thomas G. Cooney, and Lee S. Engel. 2020. “Envisioning a Better U.S. Health Care System for All: Coverage and Cost of Care.” *Annals of Internal Medicine* 172 (2_Supplement): 7–32. https://doi.org/10.7326/M19-2415.

Cutler, David. 2018. “Reducing Health Care Costs: Decreasing Administrative Spending.” U.S. Senate Committee on Health, Education, Labor and Pensions. https://www.help.senate.gov/imo/media/doc/Cutler.pdf.

———. 2020a. “David Cutler on Trimming U.S. Healthcare Costs,” 2020. https://www.harvardmagazine.com/2020/04/feature-forum-costliest-health-care.

———. 2020b. “Reducing Administrative Costs in U.S. Health Care.” Policy Proposal 2020–09. The Hamilton Project. https://www.hamiltonproject.org/wp-content/uploads/2023/01/Cutler_PP_LO.pdf.

Davis, Jessica. 2018. “JAMA: EHRs Fail to Reduce Administrative Billing Costs.” Healthcare IT News. 2018. https://www.healthcareitnews.com/news/jama-ehrs-fail-reduce-administrative-billing-costs.

Deffarges, Etienne. 2020. “Effective Strategies to Reduce Costs and Utilization in US Healthcare.” Careers in Government. March 12, 2020. https://www.careersingovernment.com/tools/gov-talk/career-advice/effective-strategies-to-reduce-costs-and-utilization-in-us-healthcare/.

Department of Financial Services. 2021. “New York State Department of Financial Services and New York State Department of Health Deliver Report and Recommendations to Reduce Health Care Costs and Complexities for the Benefit of New York Consumers.” 2021. https://www.dfs.ny.gov/reports_and_publications/press_releases/pr202110041.

Dorn, Stan, and Matthew Buettgens. 2013. “Administrative Renewal, Accuracy of Redetermination Outcomes, and Administrative Costs.” Urban Institute. https://www.urban.org/sites/default/files/publication/24031/412921-Administrative-Renewal-Accuracy-of-Redetermination-Outcomes-and-Administrative-Costs.PDF.

Douven, Rudy, Lukas Kauer, Sylvia Demme, Francesco Paolucci, Wynand van de Ven, Jürgen Wasem, and Xiaoxi Zhao. 2022. “Should Administrative Costs in Health Insurance Be Included in the Risk-Equalization? An Analysis of Five Countries.” *The European Journal of Health Economics* 23 (9): 1437–53. https://doi.org/10.1007/s10198-022-01436-y.

Eibner, Christine, Peter S. Hussey, M. Susan Ridgely, and Elizabeth A. McGlynn. 2009. “Controlling Health Care Spending in Massachusetts.” RAND Corporation. https://www.rand.org/pubs/research_briefs/RB9464-1.html.

El-Sayed, Abdul. n.d. “MichCare: Medicare for All in Michigan.” http://www.pnhp.org/slideshow/2018AM/Handout_StateSinglePayer.pdf.

Fiedler, Matthew. 2023. “Testimony of Matthew Fiedler, Ph.D. Before the United States Senate Committee on the Budget.” United States Senate Committee on the Budget. https://www.brookings.edu/wp-content/uploads/2023/10/Fiedler-SenateBudgetTestimony-FINAL.pdf.

Friedman, Gerald. 2015. “Economic Analysis of the New York Health Act.” University of Massachusetts at Amherst. https://realitiesofsinglepayer.com/wp-content/uploads/2018/03/Economic_Analysis_New_York_Health_Act_-_GFriedman_-_April_2015.pdf.

Galvani, Alison P., Alyssa S. Parpia, Eric M. Foster, Burton H. Singer, and Meagan C. Fitzpatrick. 2020. “Improving the Prognosis of Healthcare in the United States.” *Lancet (London, England)* 395 (10223): 524–33. https://doi.org/10.1016/S0140-6736(19)33019-3.

Gee, Emily, and Topher Spiro. 2019. “Excess Administrative Costs Burden the U.S. Health Care System.” *Center for American Progress* (blog). 2019. https://www.americanprogress.org/article/excess-administrative-costs-burden-u-s-health-care-system/.

Gordon, Sarah H., Benjamin D. Sommers, Ira Wilson, Omar Galarraga, and Amal N. Trivedi. 2019. “The Impact of Medicaid Expansion on Continuous Enrollment: A Two-State Analysis.” *Journal of General Internal Medicine* 34 (9): 1919–24. https://doi.org/10.1007/s11606-019-05101-8.

Gottlieb, Joshua D., and Mark Shepard. 2018. “How Large a Burden Are Administrative Costs in U.S. Health Care?” EconoFact. 2018. https://econofact.org/how-large-a-burden-are-administrative-costs-in-health-care.

Government Finance Officers Association. 2014. “Strategies for Managing Health-Care Costs.” February 28, 2014. https://www.gfoa.org/materials/strategies-for-managing-health-care-costs.

Guth, Madeline, Meghana Ammula, and Elizabeth Hinton. 2021. “Understanding the Impact of Medicaid Premiums & Cost-Sharing: Updated Evidence from the Literature and Section 1115 Waivers.” KFF. 2021. https://www.kff.org/medicaid/issue-brief/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers/.

Guzick, David S. 2020. “Can the US Health Care Industry Be Improved Without Blowing It Up?” *Family Medicine* 52 (3): 168–70. https://doi.org/10.22454/FamMed.2020.246837.

Hatzenbeler, Sam. 2022. “Controlling Health Care Costs in Washington.” Economic Opportunity Institute. https://www.opportunityinstitute.org/research/post/controlling-health-care-costs-in-washington/.

Health and Human Services Commission. 2021. “Assessment of Financial Incentives for Alternative Payment Models.” Texas Health and Human Services. https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/assessment-financial-incentives-apm.pdf.

Himmelstein, David U., and Steffie Woolhandler. 2020. “Single-Payer Reform: Heed the Evidence, Not the Soothsayers.” *American Journal of Public Health* 110 (4): 447–48. https://doi.org/10.2105/AJPH.2020.305571.

Holland, Roberta. 2018. “Electronic Health Records Were Supposed to Cut Medical Costs. They Haven’t.” HBS Working Knowledge. 2018. http://hbswk.hbs.edu/item/electronic-health-records-were-supposed-to-cut-health-costs-they-haven-t.

Howerton, Christina. 2021. “Policy Recommendations for Reducing Health Care Costs.” National Health Council. 2021. https://nationalhealthcouncil.org/additional-resources/policy-recommendations-for-reducing-health-care-costs/.

Hwang, Ann, Michael H. Bailit, Deepti Kanneganti, and Grace Flaherty. 2023. “State Strategies for Controlling Health Care Costs: Implementation Guides.” The Commonwealth Fund. 2023. https://www.commonwealthfund.org/publications/2023/jan/state-strategies-controlling-health-care-costs-implementation-guides.

Hwang, Ann, Amy M. Lischko, Tom Betlach, and Michael H. Bailit. 2022. “State Strategies for Slowing Health Care Cost Growth in the Commercial Market.” The Commonwealth Fund. https://doi.org/10.26099/m49y-2b09.

Hyman, David A. 2018. “How to Reduce Health Care Costs: Understanding the Cost of Health Care in America.” U.S. Senate Committee on Health, Education, Labor and Pensions. https://www.cato.org/sites/cato.org/files/pubs/pdf/hyman-help-testimony-6-27-2018.pdf.

Jiwani, Aliya, David Himmelstein, Steffie Woolhandler, and James G. Kahn. 2014. “Billing and Insurance-Related Administrative Costs in United States’ Health Care: Synthesis of Micro-Costing Evidence.” *BMC Health Services Research* 14 (1): 556. https://doi.org/10.1186/s12913-014-0556-7.

Keating, Elizabeth, and Claire Ewing-Nelson. 2022. “The Role Of Administrative Waste In Excess US Health Spending.” Health Affairs. 2022. https://www.healthaffairs.org/do/10.1377/hpb20220909.830296/full/.

Kocher, Bob, and Anuraag Chigurupati. 2021. “Reducing Administrative Waste in the US Health Care System” 326 (17): 1681–82. https://doi.org/10.1001/jama.2020.24767.

Massachusetts Health Policy Commission. 2021. “New HPC Report Identifies Key Health Care Cost Drivers and Calls For Immediate Action To Confront Pressing Affordability Challenges Facing The Commonwealth | Mass.Gov.” Mass.Gov. 2021. https://www.mass.gov/news/new-hpc-report-identifies-key-health-care-cost-drivers-and-calls-for-immediate-action-to-confront-pressing-affordability-challenges-facing-the-commonwealth.

———. 2022. “2022 Health Care Cost Trends Report and Policy Recommendations.” https://www.mass.gov/doc/2022-health-care-cost-trends-report-and-policy-recommendations/download.

Melnick, Glenn. 2022. “Health Care Cost Commissions: How Eight States Address Cost Growth.” *CHCF Issue Brief*, April. https://www.chcf.org/wp-content/uploads/2022/04/HealthCareCostCommissionstatesAddressCostGrowth.pdf.

Menachemi, Nir, and Paul Halverson. 2020. “Addressing Factors That Affect Health Care Costs: Recommendations for Indiana Stakeholders.” IU Richard M. Fairbanks School of Public Health at IUPUI. https://fsph.iupui.edu/doc/research-centers/fairbanks-school-of-public-health-report.pdf.

Menachemi, Nir, Saurabh Rahurkar, Christopher A Harle, and Joshua R Vest. 2018. “The Benefits of Health Information Exchange: An Updated Systematic Review.” *Journal of the American Medical Informatics Association : JAMIA* 25 (9): 1259–65. https://doi.org/10.1093/jamia/ocy035.

Michael Chernow and Harrison Mintz. 2021. “Administrative Expenses in the US Health Care System: Why So High?” *JAMA* 326 (17): 1679–80. https://doi.org/10.1001/jama.2021.17318.

Myall, James. 2019. “Assessing the Costs and Impacts of a State-Level Universal Health Care System in Maine.” Maine Center for Economic Policy. https://maineallcare.org/wp-content/uploads/2019/12/Assessing-the-Costs-and-Impacts-of-State-Level-Universal-Health-Care-in-Maine.pdf.

National Conference of State Legislatures. 2023. “10 State Strategies for Improving Medicaid.” https://www.ncsl.org/health/10-state-strategies-for-improving-medicaid.

Nevola, Adrienne, Michael E. Morris, Carrie Colla, and J.Mick Tilford. 2020. “Risk-Based Contracting for High-Need Medicaid Beneficiaries: The Arkansas PASSE Program.” *Health Policy OPEN* 2 (December): 100023. https://doi.org/10.1016/j.hpopen.2020.100023.

OECD. 2017. *Tackling Wasteful Spending on Health*. Paris: OECD Publishing. https://doi.org/10.1787/9789264266414-en.

Office for Oregon Health Policy and Research. 2010. “Oregon Administrative Simplification Strategy and Recommendations.” Oregon Health Authority Office. https://www.oregon.gov/oha/actionPlan/admin-sim-report.pdf.

Pany, Maximilian, Jeannie Fuglesten Biniek, and Tricia Neuman. 2022. “Price Regulation, Global Budgets, and Spending Targets: A Road Map to Reduce Health Care Spending, and Improve Affordability.” *KFF* (blog). 2022. https://www.kff.org/health-costs/report/price-regulation-global-budgets-and-spending-targets-a-road-map-to-reduce-health-care-spending-and-improve-affordability/.

Pestaina, Kaye, Justin Lo, Karen Pollitz, and Rayna Wallace. 2023. “CMS Prior Authorization Proposal Aims to Streamline the Process and Improve Transparency.” *KFF* (blog). February 21, 2023. https://www.kff.org/health-reform/issue-brief/cms-prior-authorization-proposal-aims-to-streamline-the-process-and-improve-transparency/.

Peter G. Peterson Foundation. 2023a. “How Can We Reduce Unnecessary Healthcare Spending in the US?” 2023. https://www.pgpf.org/blog/2023/07/how-can-we-reduce-unnecessary-healthcare-spending-in-the-us.

———. 2023b. “Almost 25% of Healthcare Spending Is Considered Wasteful. Here’s Why.” April 3, 2023. https://www.pgpf.org/blog/2023/04/almost-25-percent-of-healthcare-spending-is-considered-wasteful-heres-why.

PNHP. 2019. “Connecticut Medicaid Prospers Post Capitated Managed Care.” *PNHP* (blog). 2019. https://pnhp.org/news/connecticut-medicaid-prospers-post-capitated-managed-care/.

Porter, Sheri. 2019. “AAFP Outlines Quality Measurement Strategy for Primary Care.” *Annals of Family Medicine* 17 (2): 179–81. https://doi.org/10.1370/afm.2369.

Quincy, Lynn, and Dakota Staren. 2018. “Excess Administrative Spending in Healthcare: Significant Savings Possible.” 30. Healthcare Value Hub. https://www.healthcarevaluehub.org/application/files/4615/6373/2820/RB_30_-_Administrative_Spending.pdf.

RAND Corporation. n.d. “Hospital Price Transparency Study.” Accessed November 10, 2023. https://www.rand.org/health-care/projects/price-transparency/hospital-pricing.html.

Richman, Barak D., and Kevin A. Schulman. 2023. “Healthcare Administrative Costs and Competition Policy.” *Competition Policy Antitrust Chronicle*, no. 2023–36. https://doi.org/10.1001/jama.2021.17315.

Sahini, Nikhil R., Brandon Carrus, and David Cutler. 2021. “Administrative Simplification and the Potential for Saving a Quarter-Trillion Dollars in Health Care.” *JAMA* 326 (17): 1677–78. https://doi.org/doi:10.1001/jama.2021.17315.

Salzbrenner, Stephen G, Carrie McAdam-Marx, Maxwell Lydiatt, Brandon Helding, Lawrence M Scheier, and Patricia Wonch Hill. 2022. “Perceptions of Prior Authorization by Use of Electronic Prior Authorization Software: A Survey of Providers in the United States.” *Journal of Managed Care & Specialty Pharmacy* 28 (10): 1121–28. https://doi.org/10.18553/jmcp.2022.28.10.1121.

Scheinker, David, Barak D. Richman, Arnold Milstein, and Kevin A. Schulman. 2021. “Reducing Administrative Costs in US Health Care: Assessing Single Payer and Its Alternatives.” *Health Services Research* 56 (4): 615–25. https://doi.org/10.1111/1475-6773.13649.

Shi, Maggie. 2023. “Monitoring for Waste: Evidence from Medicare Audits.” SSRN Scholarly Paper. Rochester, NY. https://papers.ssrn.com/abstract=4546436.

Sinsky, Christine, and Mark Linzer. 2020. “Practice And Policy Reset Post-COVID-19: Reversion, Transition, Or Transformation?” *Health Affairs* 39 (8): 1405–11. https://doi.org/10.1377/hlthaff.2020.00612.

Stadhouders, Niek, Florien Kruse, Marit Tanke, Xander Koolman, and Patrick Jeurissen. 2019. “Effective Healthcare Cost-Containment Policies: A Systematic Review.” *Health Policy* 123 (1): 71–79. https://doi.org/10.1016/j.healthpol.2018.10.015.

The Commonwealth Fund. 2022. “Reduce Administrative Waste Cost Driver Targeted: Administrative Costs.” https://www.commonwealthfund.org/sites/default/files/2022-02/Hwang_health_care_cost_growth_strategy_10_administrative.pdf.

Turner, Ani, George Miller, and Samantha Clark. 2019. “Impacts of Prior Authorization On Health Care Costs and Quality.” National Institute for Health Care Reform. https://www.nihcr.org/wp-content/uploads/Altarum-Prior-Authorization-Review-November-2019.pdf.

U.S. Government Accountability Office. 2021. “Federal Low-Income Programs: Use of Data to Verify Eligibility Varies Among Selected Programs and Opportunities Exist to Promote Additional Use.” U.S. GAO. 2021. https://www.gao.gov/products/gao-21-183.

Vazirani, Anuraag A, Odhran O’Donoghue, David Brindley, and Edward Meinert. 2019. “Implementing Blockchains for Efficient Health Care: Systematic Review.” *J Med Internet Res* 21 (2): 1–12. https://doi.org/10.2196/12439.

Waters, Teresa, and Michael Karpf. 2020. “Healthcare Reform in the U.S. Must Be Driven by Policy and Data, Not Politics and Ideology.” *Journal of Family Medicine and Health Care* 6 (1): 24. https://doi.org/10.11648/j.jfmhc.20200601.15.

Wiener, Joshua M., Melissa Romaire, Nga (Trini) Thach, Aubrey Collins, Konny Kim, Huiling Pan, Giuseppina Chiri, et al. 2017. “Strategies to Reduce Medicaid Spending: Findings from a Literature Review.” Kaiser Family Foundation. https://files.kff.org/attachment/Issue-Brief-Strategies-to-Reduce-Medicaid-Spending-Findings-from-a-Literature-Review.

Willging, Cathleen E., David H. Sommerfeld, Gregory A. Aarons, and Howard Waitzkin. 2014. “The Effects of Behavioral Health Reform on Safety-Net Institutions: A Mixed-Method Assessment in a Rural State.” *Administration and Policy in Mental Health* 41 (2): 276–91. https://doi.org/10.1007/s10488-012-0465-1.

Yu, Jia, and Yi Zhang. 2017. “Comparison of Single-Payer and Non Single-Payer Health Care Systems: A Study of Health Administration Efficiency.” *Modern Economy* 08 (06): 816–33. https://doi.org/10.4236/me.2017.86057.

E. Literature Review Protocol

NORC conducted a literature review to understand effective proposed and implemented methods for reducing health care administrative costs at the state level. Specifically, the goal of this review was to answer the following questions:

1. What approaches are states currently using to reduce administrative health care costs, and on what areas are they focusing?
2. Have any of the approaches been evaluated, and what were the results and findings?
3. How effective have the approaches been at reducing costs while maintaining or increasing health care quality?
4. What barriers have states faced in implementing administrative cost reduction strategies?
5. What approaches have experts recommended to reduce administrative health care costs?
6. What are the barriers to implementation of expert recommendations?
7. What legal and administrative limitations does the New Mexico government face in addressing reductions in administrative costs (e.g., Is the government allowed to mandate an interoperable EHR system or does this require new legislation)?

NORC focused the scan on specific policies that interest the New Mexico LHHS, including Medicaid and health care programs administered by the state (state employee health insurance, retiree health insurance, Albuquerque public school district, public schools generally).

Search Parameters

We conducted searches of both grey literature and peer-reviewed literature. For grey literature, we used Google and followed the search parameters defined below. For peer-reviewed literature, we used PubMed, Google Scholar, and PubMed Central, and followed the search parameters defined below, using the University of Chicago library system for access to articles.

We only searched for articles and reports dated from **2013 or later** to capture the most up-to-date information and methodologies. Our primary search terms were **"Health care," "Administrative,"** and **"Cost reduction,"** which we searched for in combination with a variety of secondary search terms related to the research questions. The following is a starting list of secondary search terms:

Secondary Search Terms

Spending reduction	Efficiency	Evaluate/ion
Burden	State	Reduce/ion
Overhead	Multipayer	Results
Health care	Strategy	Barrier

Spending reduction	Efficiency	Evaluate/ion
Methods	Recommendation	Limit/ation
Processes	Effectiveness	Medicaid

Storing and Screening Results

For articles or webpages that met initial relevance through search terms, we saved the full text to Zotero, a reference management system. Zotero has built-in systems to identify duplicate articles, which ensured that multiple copies of the same article were not uploaded. Once the initial search was complete, we exported the files from Zotero and imported them into Covidence software, which we used to store articles and reports with citations and to facilitate the screening of results to apply inclusion/exclusion criteria. Covidence is compatible with reference managers and allows uploading citations and full-text PDFs from reference managers. Covidence supports both title/abstract and full-text screening, allows for multi-user collaboration, and provides support for data extraction and risk of bias assessment.

Inclusion/Exclusion Criteria

Exhibit 7 displays our initial parameters for inclusion/exclusion criteria.

Exhibit 7. Inclusion/Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
• Published in or after 2013 • Discusses administrative burden in the U.S. • Discusses cost-reduction strategies • Discusses state-based strategies • Discusses policy-based strategies	• Published before 2013 • Discusses administrative burden outside the U.S. • Does not discuss cost-reduction strategies • Discusses federal, local, or health-system strategies • Focuses on disease-specific or clinical methods • Focuses on policy unique to COVID public health emergency

Google Search Strategy

Exhibit 8. Google Search Terms

#	Search
1	(((“Administrative burden” OR “"administrative costs” OR “administrative spending”)) AND health care) AND (policy OR strategy OR evaluation)
2	(((“Administrative burden” OR “administrative costs” OR “administrative spending”)) AND Medicaid) AND (policy OR strategy OR evaluation)
3	(Health care AND (“administrative burden” or “administrative costs” OR “administrative spending”)) state policy recommendation
4	(Health care AND (“administrative burden” or “administrative costs” OR “administrative spending”)) reduction policy recommendation United States

#	Search
5	Strategies to reduce administrative burden state health programs
6	Strategies to reduce administrative burden Medicaid
7	State policy strategy to reduce health care administration costs
8	Strategies to reduce health care administrative costs benefits eligibility
9	Strategies to reduce health care administrative costs benefits verification
10	Strategies to reduce health care administrative costs claims
11	Strategies to reduce health care administrative costs billing
12	Strategies to reduce health care administrative costs coordinated care
13	Strategies to reduce health care administrative costs reimbursement structure
14	Strategies to reduce health care administrative costs electronic medical record
15	Strategies to reduce health care administrative costs workforce
16	Strategies to reduce health care administrative costs low-value care

Google Scholar Search Strategy

Exhibit 9. Google Scholar Search Terms

#	Search
1	(((((((“administrative burden” OR “administrative costs” OR “ billing and insurance-related costs” OR “BIR”)) AND (health care OR health care)) AND (“United States”)) AND “last 10 years”[PDat])) AND “last 10 years”[PDat])
2	Strategies to reduce health care administrative costs burden United States
3	Strategies to reduce “health care administrative costs” burden United States
4	Policies to reduce “health care administrative costs” United States
5	“Reduce” AND “billing and insurance related costs” AND “health care”
6	(“Health care” or “healthcare”) AND (“reduce” OR “reducing”) AND (“administrative costs” OR “Administrative burden”) AND (“United States” OR “US” OR “USA”)
7	“Administrative burden”[Abstract] OR “administrative costs”[Abstract] OR “administrative spending”[Abstract] AND (health care OR healthcare)
8	“Administrative burden”[Abstract] OR “administrative costs”[Abstract] OR “administrative spending”[Abstract] AND (health care OR health care) AND “Utah”
9	“Administrative burden”[Abstract] OR “administrative costs”[Abstract] OR “administrative spending”[Abstract] AND (health care OR health care) AND “Louisiana”
10	“Administrative burden”[Abstract] OR “administrative costs”[Abstract] OR “administrative spending”[Abstract] AND (health care OR health care) AND “California”
11	“Administrative burden”[Abstract] OR “administrative costs”[Abstract] OR “administrative spending”[Abstract] AND (health care OR health care) AND “Vermont”

PubMed Central Search Strategy

Exhibit 10. PubMed Central Search Terms

#	Search
1	(((((((“Administrative burden” OR “administrative costs” OR “administrative spending”)) AND (health care OR health care)) AND (“state policy” OR strategy)) AND “last 10 years”[PDat])) AND “last 10 years”[PDat])
2	(((((((“Administrative burden”[Abstract] OR “administrative costs”[Abstract] OR “administrative spending”[Abstract])) AND (health care OR health care)) AND (“state policy” OR strategy)) AND “last 10 years”[PDat])) AND “last 10 years”[PDat])

PubMed Search Strategy

Exhibit 11. PubMed Search Terms

#	Search
1	(((((((“Administrative burden” OR “administrative costs” OR “administrative spending”)) AND (health care OR health care)) AND (“United States”)) AND “last 10 years”[PDat])) AND “last 10 years”[PDat])
2	(((((((“Administrative burden”[Abstract] OR “administrative costs”[Abstract] OR “administrative spending”[Abstract])) AND (health care OR health care)) AND (“state policy” OR strategy)) AND “last 10 years”[PDat])) AND “last 10 years”[PDat])

F. Interview Protocol

Probing Questions:

- Let's start with a really big question. What comes to mind as top opportunities for reducing health care administrative costs? And remember, this project is for the Legislature, so big ideas are equally welcomed.

If needed: Topics we've already heard or read about range from improving the interoperability of existing technology, medical malpractice legislation or other workforce solutions, streamlining prior and continuing authorizations to Managed Care Organization (MCO) elimination, and everything in between.

- What's resonating with you?
- Any other thoughts on other opportunities or strategies?

Based on the answer to the first question, probe on the following topics:

Everyone

- Technological strategies
  - Probe: all-payer claims databases (APCDs)—use for price transparency
  - Probe: ensure compatible platforms between organizations ("common digital infrastructure"), common data standards/health information exchange (HIE)
  - Probe: interoperability to build a bridge between clinical and administrative data

Everyone

- Reimbursement strategies
  - Probe: single payer
  - Probe: bundled payments for episodes—standardized across MCOs
  - Probe: alternative payment models (APMs)/capitated models

Providers/Payers/State

- Claims and billing processes
  - Probe: standardization and automation of claims procedures
  - Probe: standard set of payment requirements
  - Probe: standard payment/billing forms
- Clinical strategies
  - Probe: reforming prior authorization (PA)/continuing authorization

    - Including: reduction in PA; use of pharm techs for Rx PA; standardizing services requiring PA; standardize PA submission process; automate PA; electronic PA (ePA); strategic application of PA; sunset and gold card programs
  - Probe: complex care management/chronic disease management
  - Probe: reduce low-value care (benchmarking, clinical decision support, education, optimizing use of medication, reduce unnecessary procedures, expand hospice access, pioneering accountable care organization strategies to reduce overuse) *ask payers?

Providers/Payers

- Measurement-based strategies
  - Probe: “harmonizing” quality metrics—CMS and commercial metrics should be the same
  - Probe: facilitate automated data collection and quality measure reporting
- Contractual/legal strategies
  - Probe: the American College of Physicians (ACP) has proposed medical liability reform with a focus on patient safety and reducing errors and including caps on noneconomic damages, piloting communication and resolution programs, and safe harbor protections for physicians who provide care consistent with evidence-based guidelines

State

- Eligibility and benefits verification
  - Probe: administrative renewal
  - Probe: continuous enrollment
  - Patient-centered medical homes

Closing

- *If not clear:*
  - We talked about a number of opportunities for reducing administrative costs. Which do you think would make the biggest impact in New Mexico?
  - Which do you think is most palatable to stakeholders across the state?
- Is there anything else we didn’t ask about that you want to share related to the topic of reducing administrative costs?
- Anyone else you think we must talk to for this project?

G. Interview List

Exhibit 12. A Complete List of Stakeholder Interviews

Interviewee	Organization Type	Organization
Annie Jung	Nonprofit health care organization	Executive director, New Mexico Medical Society
Brenna Gaytan	For-profit health plan	Director of government relations, Blue Cross Blue Shield of New Mexico (BCBSNM)
Bret Goebel	Nonprofit hospital	CFO, Guadalupe County Hospital
Charles Sallee	Legislative committee	Deputy director, New Mexico Legislative Finance Committee
Christina Campos	Nonprofit hospital	CEO, Guadalupe County Hospital
Colin Baillio	Government agency	Deputy superintendent, Office of the Superintendent of Insurance
John Cook	For-profit health plan	VP of New Mexico Programs and Network Management, BCBSNM
Kari Armijo	Government agency	Acting secretary, Human Services Department
Lorelei Kellogg	Government agency	Acting Medicaid director, Human Services Department
Maggie McCowen	Nonprofit health care organization	Director, Behavioral Health Providers Association of New Mexico
Rodney McNease	Nonprofit hospital	Administrator, University of New Mexico Hospitals
Russell Toal	Legislative committee	Contract consultant, Legislative Finance Committee
Stefany Goradia	For-profit health care technology company	HealthTech Rx
Terri Stewart	Nonprofit health care technology organization	President and CEO, SYNCRONYS
Tony Hernandez	Nonprofit health care organization	VP and GM of Medicare transformation, Presbyterian Health Care Services
Troy Clark	Nonprofit health care organization	President and CEO, New Mexico Hospital Association
Sen. Martin Hickey[11]	State legislature	State Senator, New Mexico Legislature
Mary Feldblum	Nonprofit health care organization	Executive director, Health Security for New Mexicans Campaign
Kristi Martine	Tribal 638 clinic	Interim clinic administrator, Pine Hill Health Center

[11] Senator Hickey was consulted but not formally interviewed.

H. Analytic Review Protocol and Findings

This analytic appendix provides findings from eight analyses to better understand how New Mexico's health care administrative costs, revenues, and other measures compare to the rest of the United States.

Data sources

Hospital Cost Reports

To understand administrative costs in New Mexico, we used HCRIS data, pulling error-corrected Medicare hospital cost reports for the years 1996 to 2021. Hospital cost reports are reports that Medicare-certified hospitals and other institutional providers are required to submit. They contain information such as facility characteristics, utilization data, cost and charges by cost center, Medicare settlement data, and financial statement data.

IRS 990 Forms

IRS 990 forms are forms that tax-exempt (e.g., nonprofit) organizations fill out. They provide information about organizational revenues, expenses, assets, and liabilities. Using the tax ID by state files and individual 990 forms, we looked at individual tax submissions to observe what proportion of hospital revenues are paid to board officers/executives and what proportion of revenues are spent on charitable community programs.

Various Rule-Making Files

There are various rule-making files; our analysis focused on the Medicare Physician Fee Schedule and the Inpatient Prospective Payment System. The Medicare Physician Fee schedule provides a complete list of fees that Medicare uses to pay doctors, providers, and suppliers on a fee-for-service basis. The Inpatient Prospective Payment System categorizes each case into a diagnostic-related group and assigns a payment weight to it. The payment weight is determined based on the average resources to treat Medicare patients in that group. We used these files to determine what proportion of relative value units (RVUs) are considered administrative. We then estimated the proportion of government payments to providers that are due to administrative costs.

Analytic questions

Exhibit 13. Analytic Review Questions

Data Source	Questions
Hospital cost reports	1. What proportion of hospital costs are attributable to administrative costs? How does this differ by hospital? How have administrative costs changed over time? 2. How do NM hospitals compare to similar hospitals across the country?

Data Source	Questions
	3. How do administrative cost burdens relate to various observable attributes of hospital cost structure (e.g., payer mix, revenue efficiency/margin)? Are NM hospitals odd in any particular regard? Are uncompensated care costs related to administrative costs?
IRS 990 forms	4. To the extent observable, what proportion of hospital revenues are paid out to board officers and executives? 5. To the extent observable, what proportion of revenues are spent on charitable community programs, such as meals?
Various rule-making files	6. What proportion of government payments to providers are due to administrative costs? 7. What changes can have substantial impacts on administrative cost reduction?

Analytic Overview

Analytic approach and limitations

Hospital cost report data were cleaned and analyzed in R v. 4.3.1. We selected variables of interest and then cleaned the new subset of data. We removed data for years before 2010, along with variables that contained more than 25,000 missing values. Following the inclusion of variables, we calculated proportions of interest, including administrative costs to total costs and administrative costs to the number of beds. Summary statistics, including the aggregate total, mean, median, 25th percentile, 50th percentile, and standard deviation of measures of interest were then calculated for all hospitals, only New Mexico–based hospitals, and only non-New Mexico hospitals for data collected in 2019 (the most current complete year of data not during the height of the COVID-19 pandemic). These measures were also calculated for different subgroups, including the size of the hospital, who owns the hospital, and whether the hospital is in a rural or urban area. We analyzed relationships between different measures graphically and by running linear regressions.

IRS 990 reports were combed through manually, and total revenues, revenues spent on charitable programs, and amounts paid to board officers and executives were pulled out and inserted into Excel. We then calculated and compared proportions of total revenue to the other measures.

Lastly, we analyzed Medicare and Medicaid fee schedules using Excel. Malpractice relative value units (RVUs) and facility overhead RVUs were analyzed proportionally to total payment rates as well as physician labor/work RVUs by Healthcare Common Procedure Coding System (HCPCS) code.

Hospitals were categorized by ownership type (for-profit, nonprofit, government owned), rurality (rural, urban), and size (micro, small, medium, large). Rurality was determined based on a hospital's geographic location per the Inpatient Prospective Payment System (IPPS) Final Rule File (Centers for Medicare & Medicaid Services 2023b). Hospital size was determined based on bed count (i.e., number of hospital beds available). Micro hospitals have zero to 10 beds, small hospitals have 11 to 100 beds, medium hospitals have 101 to 499 beds, and large hospitals have more than 500 beds (Slyter 2018).

Results are organized by topic:

- Administrative spending: examines spending on health care administration as a percent of total expenditures as well as administrative costs over time.
- Operating margins: examines the profit per dollar of sales after accounting for additional expenditures.
- Revenue per inpatient days: examines the amount of revenue each hospital makes per inpatient day.
- Number of inpatient days: examines the number of inpatient days per available bed.
- Fee schedules: examines malpractice RVUs vs. to work RVUs.

Results

Administrative Spending

When comparing hospitals of the same ownership, rurality, and size (other than large hospitals), the proportion of total costs that are spent on health care administration is significantly higher in New Mexico hospitals than other U.S. hospitals. For example, administrative spending in New Mexico micro hospitals is 14.62 percent higher than that of micro hospitals in the rest of the United States.

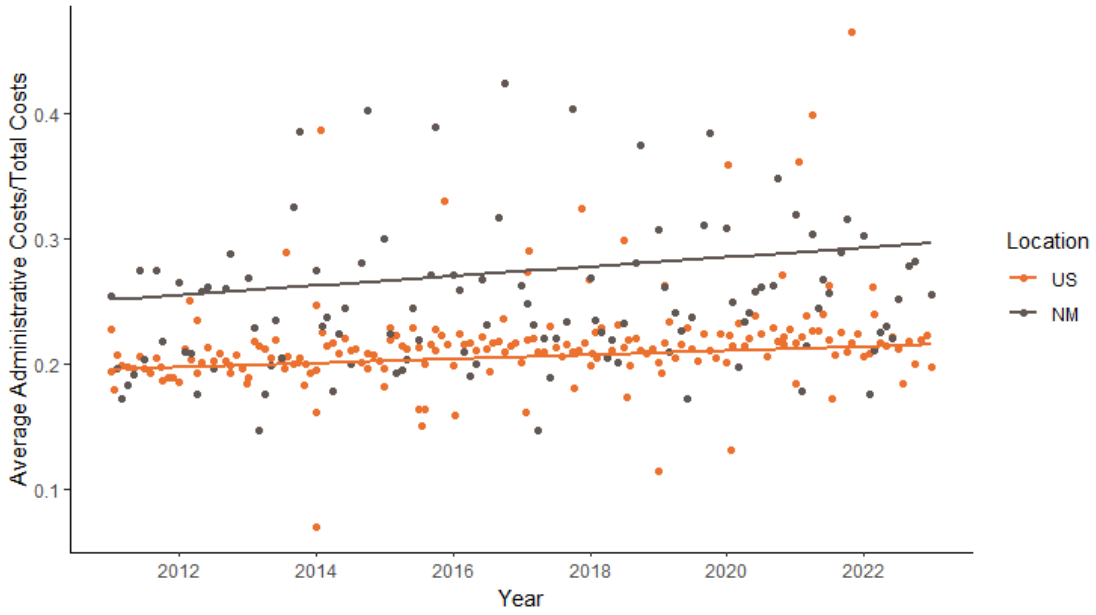
Exhibit 14. Spending on Health Care Administration by Hospital Ownership, Rurality, and Size

Hospital Type	Administrative Spending (% of Total Expenditures)	
	New Mexico	United States
Ownership		
For-profit	24.17% ***	21.58%
Government	28.19% ***	19.62%
Nonprofit	25.78% **	21.07%
Rurality		
Rural	26.75% ***	20.42%
Urban	25.39% ***	21.18%
Size		
Micro	36.59% ***	20.97%
Small	28.19% ***	20.99%
Medium	24.99% **	21.12%
Large[a]	27.45%	20.09%
Overall	27.10% ***	20.98%

Data Source: HCRIS Hospital Cost Reports
Notes: Percentages are based on the median value of administrative costs divided by total costs for each hospital subgroup.
[a] There is only one large hospital in New Mexico, limiting further analysis.
**p<.01., ***p<.001

Administrative spending has been increasing at a similar rate in both New Mexico and the rest of the United States since 2010. The proportion of total costs spent on health care administration is consistently higher in New Mexico compared to the rest of the country.

Exhibit 15. Spending on Health Care Administration over Time



Data Source: HCRIS Hospital Cost Reports
Notes: Points are based on the median value of administrative costs divided by total costs.

Operating Margins

Overall, nonprofit hospitals and urban hospitals have similar operating margins in New Mexico and the United States. When examined by subgroup, New Mexico nonprofit hospitals and urban hospitals have statistically different operating margins. New Mexico nonprofit hospitals make less profit per dollar of sales after paying for variable costs (e.g., wages and materials), compared to U.S. hospitals, whereas urban New Mexico hospitals are significantly more profitable than U.S. urban hospitals.

Exhibit 16. Estimates of Operating Margins by Hospital Ownership, Size, and Rurality

Hospital Type	Operating Margin	
	New Mexico	United States
Ownership		
For-profit	0.07101	0.03740
Government	0.01121	-0.00214
Nonprofit	0.01832**	0.02695
Rurality		
Rural	0.04570	0.01567

Hospital Type	Operating Margin	
	New Mexico	United States
Urban	0.03007*	0.02990
Size		
Micro	-0.62486	-0.04646
Small	0.03332	0.01284
Medium	0.06180	0.03583
Large	0.03007	0.03373
Overall	0.04570	0.02323

Data Source: HCRIS Hospital Cost Reports
Notes: Percentages are based on the median operating margin for each subgroup. Operating margin was calculated by dividing the value of the net income minus the income from contributions, investments, and government appropriations by the sum of the net patient revenue and all other income minus the income from contributions, investments, and government appropriations.
[a]There is only one large hospital in New Mexico, limiting further analysis.
*p<0.05., **p<.01

Revenue per Inpatient Days

Revenue by inpatient days, both overall and by hospital subgroup, is not statistically different in both New Mexico and U.S. hospitals. New Mexico hospitals, as whole, make similar profits comparable to other hospitals in the United States.

Exhibit 17. Estimates of Revenue per Inpatient Day by Hospital Ownership, Rurality, and Size

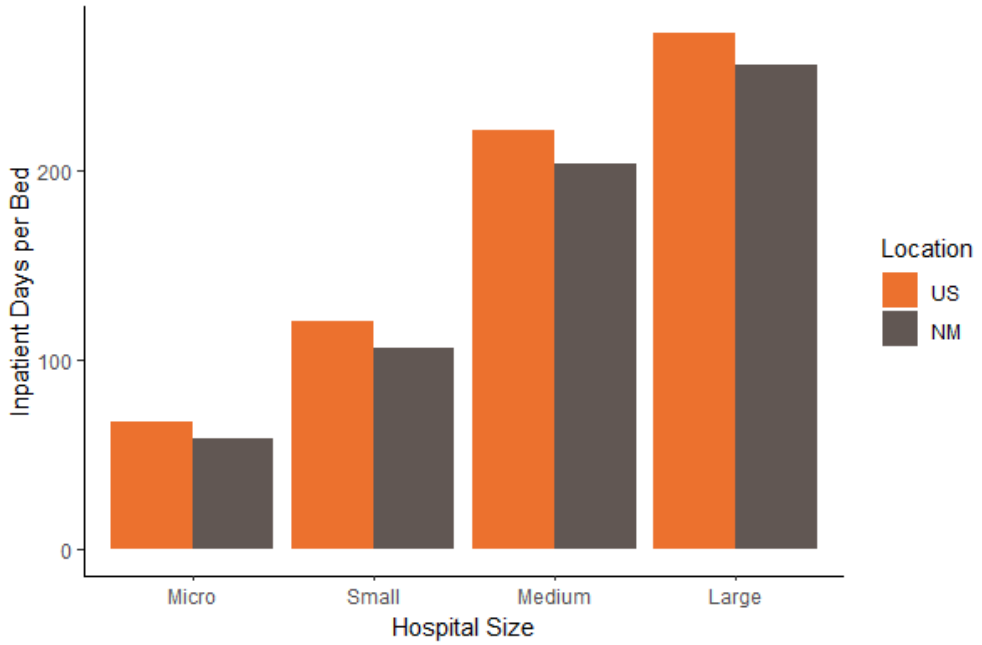
Hospital Type	Revenue (per Inpatient Day)	
	New Mexico	United States
Ownership		
For-profit	$4,519.98	$5,320.75
Government	$11,010.30	$4,592.98
Nonprofit	$5,188.21	$4,464.09
Rurality		
Rural	$8,536.62	$5,742.98
Urban	$3,664.48	$3,792.373
Size		
Micro	$2,316.42	$13,832.93
Small	$9,485.85	$6,183.39
Medium	$3,561.30	$3,544.50
Large[a]	$3,664.48	$2,689.78
Overall	$4,623.22	$4,512.42

Data Source: HCRIS Hospital Cost Reports
Notes: Numbers represent the median total revenue divided by the number of inpatient days for each subgroup.
[a]There is only one large hospital in New Mexico, limiting further analysis.

Number of Inpatient Days

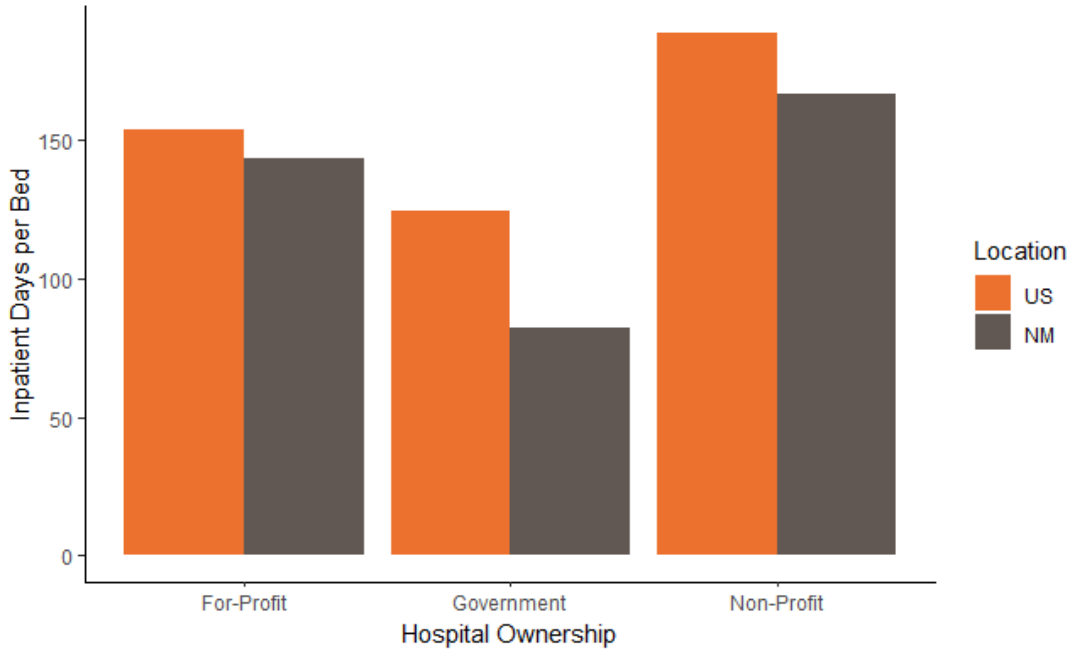
New Mexico hospitals have significantly different inpatient days per bed than other U.S. hospitals. On average, U.S. hospitals have approximately 30 more inpatient days per bed compared to New Mexico hospitals (p<.001). This relationship is present among all different hospital subgroups. The number of inpatient days per bed is negatively and significantly associated with the proportion of administrative costs to total costs (p<.001). That is, as the proportion of inpatient days per bed increases, administrative costs tend to decrease.

Exhibit 18. Proportion of Inpatient Days per Bed by Hospital Size



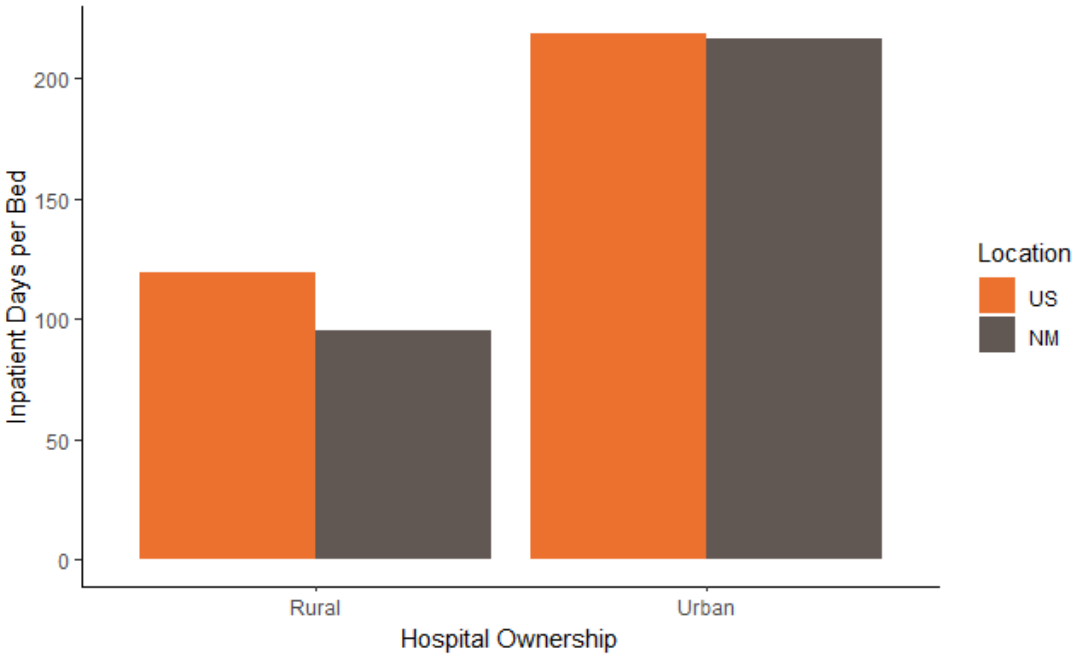
Data Source: HCRIS Hospital Cost Reports
Notes: Bars depict the median proportion of inpatient days per bed.

Exhibit 19. Proportion of Inpatient Days per Bed by Hospital Ownership



Data Source: HCRIS Hospital Cost Reports
Notes: Bars depict the median proportion of inpatient days per bed.

Exhibit 20. Proportion of Inpatient Days per Bed by Rurality



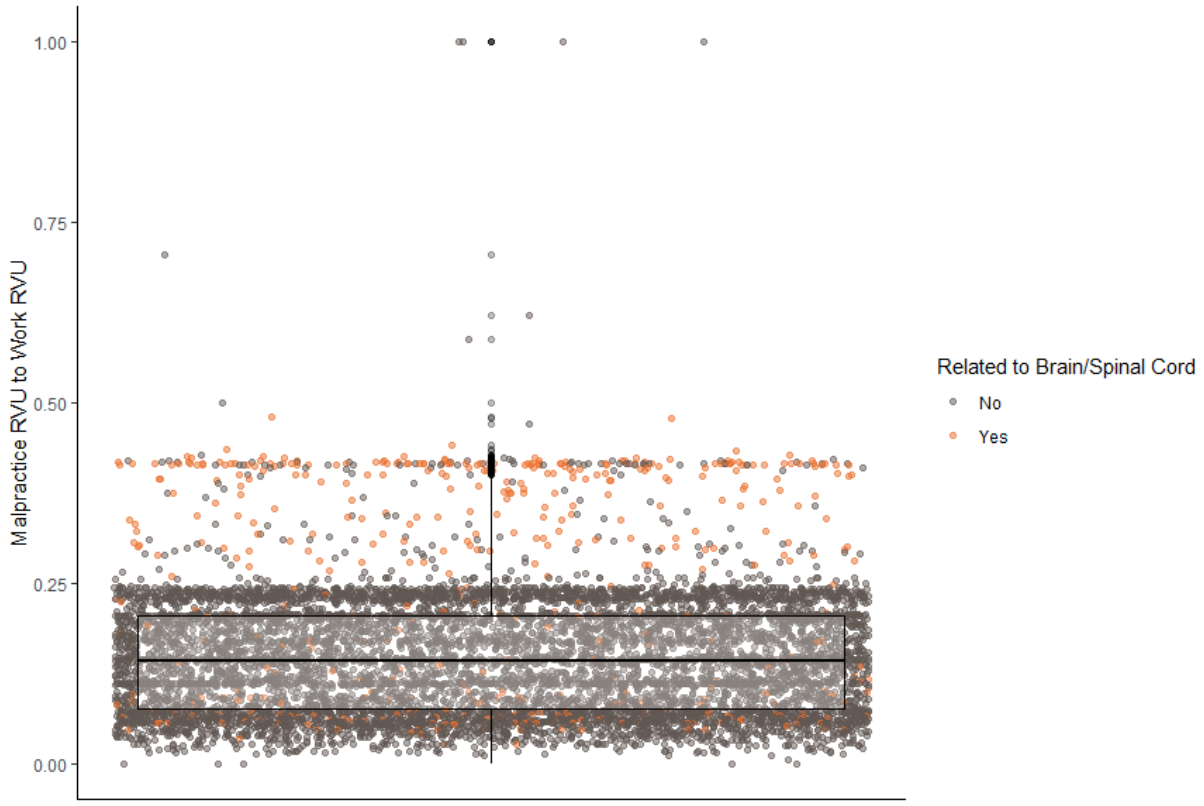
Data Source: HCRIS Hospital Cost Reports
Notes: Bars depict the median proportion of inpatient days per bed.

Medicaid/Medicare Fee Schedules and IRS 990 Forms

Rulemaking Files

New Mexico hospitals can save on administrative costs by implementing tort reform, specifically on higher-risk procedures such as those involving the brain and spinal cord. When comparing malpractice RVUs to work RVUs, most procedures that have above average ratios involve the brain and spinal cord. Implementing tort reform can lower the cost of malpractice RVUs for procedures that have significant malpractice risk.

Exhibit 21. Estimates of Malpractice RVU to Work RVU



Data Source: Medicare Fee Schedules (CMS)

IRS 990 Forms

We compared total revenues of nonprofit hospitals to the amount the hospitals spent on wages for executives and trustees and on charitable programs/donations. IRS 990 forms showed that there are not significant proportions of hospital revenues being spent on compensating executives/trustees or charitable programs. Better data reporting would be required to provide more detailed recommendations and comparisons.