Payment Options for New Mexico's Health Security Act

Report to the New Mexico Office of the Superintendent of Insurance

March 18, 2022

Miriam Laugesen, Ph.D.
Michael Gusmano, Ph.D.

Table of Contents

List of Figures 3

List of Tables **3**

Executive Summary 4

Introduction 6

Part I: Health Care Pricing in the United States 7

Health Care Expenditure and High Prices for Health Care *7*

Private Sector Pricing Models *9*

Pricing Models in Medicare and Medicaid *11*
Medicare's Fee Schedule and Medicare Payment Reforms 11
Medicaid 14

Part II: Best Practices from High-Achieving Health Systems 16

1: Multi-Payer Models Are Feasible *16*

2: Prices are Standardized and Held to Budget Targets *18*

3: Fee-for-Service Payment Models Are Widespread *20*

4: Administrative Costs Can be Lowered *21*

Part III: Recommendations for New Mexico 24

1. Standardize Health Care Pricing Using the Medicare Fee Schedule *24*
Adopt the Medicare Fee Schedule 25
Determine the Mix of Caps, Floors, and Rates 26
Determine the Scope of Standardization Across Payers 28
Decide on Pricing Update Policies 33

2. Develop Payment Policies to Incentivize Providers *34*
Incentivize primary care physician participation 34
Incentivize HSA Participation by Eliminating Claw-Back Policies 37

4. Simplify Health Insurance *38*
Develop Consistent Payment Rules 38
Review Patient Insurance Verification Processes to Reduce Provider Financial Risks for Participating Providers 39
Require Uniform Utilization Review and Pre-Authorization Policies 40

4: Develop Evaluation Frameworks of Payment Adequacy *41*
Develop Measures of Payment Adequacy 41
Support "All Payer" Price Standardization and Claims Databases (APCD) 44

Appendix 45

Existing Insurance Coverage in New Mexico *45*

References 47

List of Figures

Figure 1 Health Security Act Goals 6

Figure 2 International Medical Prices for Privately Funded Services as a Percentage of Service Prices in the United States 8

Figure 3 Stylized Illustration of How Commercial Insurers Determine Payments for Hospitals' and Physicians' Services 10

List of Tables

Table 1 Factors Influencing Negotiated Private Sector Prices (Physician Services) 11

Table 2 Components of the Resource-Based Relative Value Scale (RBRVS) 12

Table 3 Fee-for-Service Pricing Models used by Medicaid and State Payers 15

Table 4 Comparison of Medicare, Employer-Sponsored and Medicaid Rates for Professional Fees in Albuquerque, New Mexico (2018) 28

Table 5 All Payer Options for Price Standardization 32

Executive Summary

This report seeks to educate policymakers, providers, advocates, and patients on how health systems create more streamlined and sustainable health care payment mechanisms.

Health Care Expenditure and Pricing Models

Private providers and private payers largely set their own prices for health care in the United States—which has led to higher health care prices. In addition, consolidation within health care is leading to increased prices. In contrast, Medicare has been more successful in holding prices steady using a fee schedule.

Best Practices from High-Achieving Health Systems

Best practices are reviewed from nations with universal health insurance programs which have coherent payment policies that address prices while maintaining access. Reforms from selected U.S. states are also reviewed.

1: Multi-Payer Models Are Feasible: Success in improving coverage and affordability is achievable with multiple payers if provider payment policies are structured to reduce administrative complexity and prices are aligned with affordability goals.

2: Prices are Standardized Within Budget Targets: Other countries have developed institutional arrangements to implement standardized pricing across payers overseen by government under a formalized statutory framework. Prices are held in check by overall health care spending targets. Budget targets have been adopted in some U.S. states.

3: Fee-for-Service Payment Models Are Widespread: In most OECD countries, most physicians working in physician offices are paid on a fee-for-service basis. Rather than fee-for-service driving high prices in the U.S., this suggests that absolute prices, and efforts to limit system expenditure are important considerations.

4: Administrative Costs Can be Lowered: High-performing health systems keep administrative costs low by standardizing fees and processes. Simplification of health insurance administration is critical for consistency across payers and providers.

Recommendations for Health Security in New Mexico

New Mexico has an opportunity to unify programs under a multi-payer model, exploring waiver options for federal programs, and to create a more streamlined health care system.

1. Standardize payments and adopt the Medicare Fee Schedule for use as an all-payer model. Develop update mechanisms.

2. Develop payment policies that incentivize primary care to participate, build the primary care medical home concept, and reduce the administrative burdens.

3. Simplify health insurance with consistent payment rules and enrollment verification processes. Require payers to develop standardized all-payer preauthorization and payment rules.

4. Develop evaluation frameworks for payment adequacy informed by provider feedback as well as performance metrics; and invest in all-payer claims data infrastructure.

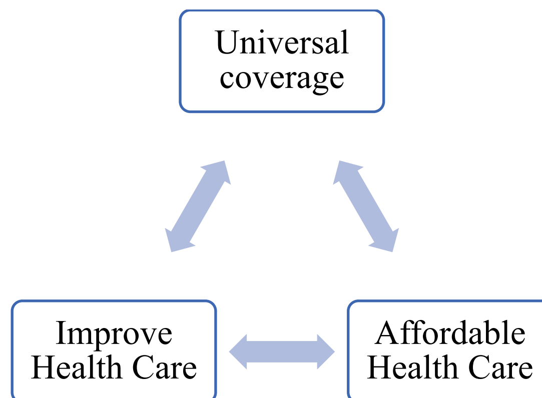
These policies are designed to ensure New Mexico has a sustainable health care system that provides universal coverage—and a system that everyone can afford to access.

Introduction

This report explores issues around the future government management of health care pricing under New Mexico's "Health Security Act" (HSA). Specifically, the report examines issues related to payment options that could be utilized under the HSA in New Mexico. We focus on payment rates for providers of services by professionals such as physicians, nurse practitioners, and psychologists.

The bill, as introduced by the New Mexico State Legislature in 2019, would expand insurance coverage options for people in New Mexico. The expansion of coverage and consolidation of public programs reflects growing recognition that changes are necessary to improve health and health insurance for everyone. Discussions over many years suggest stakeholders support expansion of insurance coverage, affordable health care along with adequate provider reimbursement rates, and simplification of health care coverage.[1] These goals are included in the HSA as expressed (Figure 1) below:

Figure 1 Health Security Act Goals



This report was commissioned by the New Mexico Office of Superintendent of Insurance with a charge to bring U.S. and international evidence to bear on the issue of how a plan such as the HSA would pay for physician and other professional services. Our experience in other multi-payer systems, our research in New Mexico and U.S. payment policy informs our analysis.

Part I: Health Care Pricing in the United States

Due to the difficulty of establishing market prices, U.S. public and private payers often use a mix of prevailing prices within geographic areas (typically negotiated with providers) and fee schedules for services. In this section we provide an overview of public and private payment models and health care pricing policies used both throughout the United States and in New Mexico.

Health Care Expenditure and High Prices for Health Care

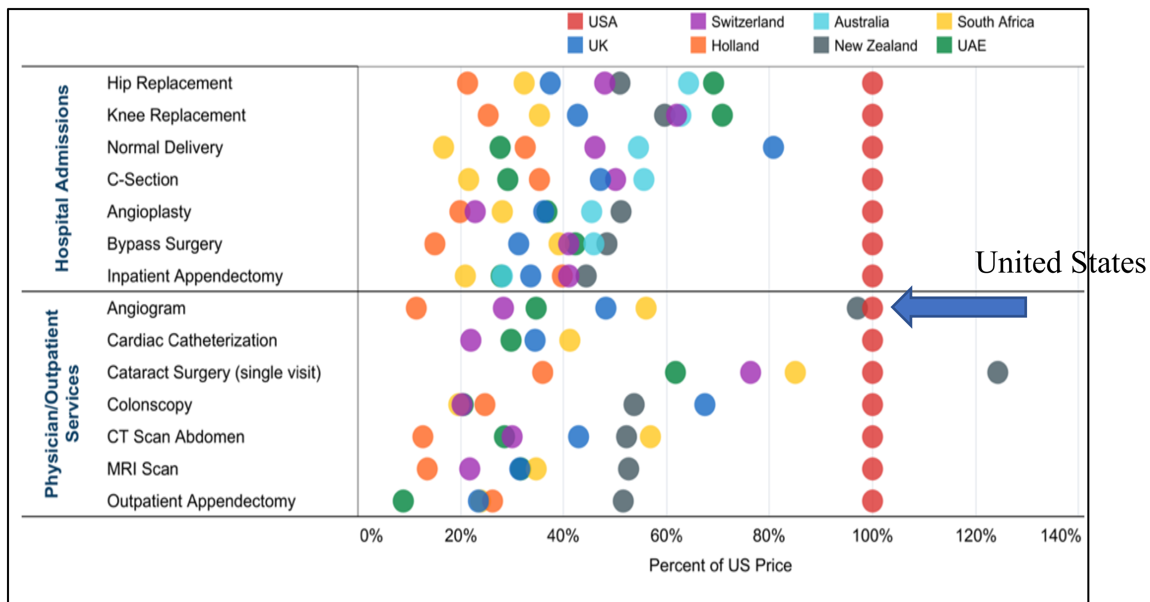
The U.S. spends more than any other country in the world on healthcare. Ultimately, this translates to higher public and personal expenditures, and less money available for other goods and services. To understand why the U.S. has higher health expenditure, it is useful to understand how health expenditure is driven by two fundamental factors: quantity (Q) or utilization multiplied by the price (P) of the goods and services used. Quantity changes can be influenced by underlying population changes, such as increased birthrates or aging of the population.

Higher U.S. expenditure is not explained by people receiving more services, on average. Researchers have found that people in other countries where healthcare expenditures are lower, do *not* receive less healthcare—in some cases they receive *more* services.[2] Nor do Americans receive higher quality care: U.S. providers charging the highest prices are no different in terms of quality or efficiency, from those charging lower prices.[3] There is a common opinion that the major cause of high health care costs is excessive volume of care, however, Joseph White, among others, argues that we often overstate how much health care spending care be reduced by eliminating "unwarranted" care.[4] Similarly, Berwick and Hackbarth argue that "overtreatment" is only a modest portion of supposed "waste" in the health-care system.[5] These critiques are reinforced by international comparisons,. which find that high U.S. health care spending is driven by price, not by volume.[6]

The reason the United States spends more on health care is that the U.S. has extraordinarily high prices for medical services.[7] We can compare differences in relative health sector prices by looking at the same services. Prices in the U.S. are about 28% higher than the OECD average. Likewise, (see Figure 2) prices elsewhere are clustered closer to the prices of other countries even for privately paid services in other countries, with most costing between 20 to 50% less than U.S. prices. One area where prices are more alike, (though still higher in the United States) is primary care physician fees, where U.S. fees are closer to international levels.[8]

This is suggestive that the U.S. high prices reflect differentials between specialty and primary care services.

Figure 2 International Medical Prices for Privately Funded Services as a Percentage of Service Prices in the United States



Source: Modified and Reproduced from: John Hargraves and Aaron Bloschichak 2019. *International comparisons of health care prices from the 2017 iFHP Survey* Health Care Cost Institute.

The reason health care prices are so high in the U.S. is that prices in the U.S. are uncoordinated and determined by thousands of public and private payers. Prices for drugs and other services are artificially kept high,[9] in some cases by legislative limits that prevent public payers such as Medicare from leveraging its purchasing power. Technological improvements in health care have driven increases in cost all over the world,[10] but high prices and a refusal to regulate them differentiate the U.S. from other countries in terms of their impact on health care costs. Private providers and payers have largely set their own prices for health care in the United States. As Michael Chernew and colleagues put it, "decades of work has demonstrated that our market-based, decentralized health-care system leads to high prices that seem far from efficiently determined."[11] Likewise, former Administrator of the Centers for Medicare and Medicaid Services (CMS), Don Berwick explains that fragmentation of the health finance and delivery systems in the U.S. contribute to these problems "because no single group of participants -- physicians, hospitals, public or private payers or employers – takes full responsibility for guiding the health of a patient or community."[12] This differs from the approach in most other

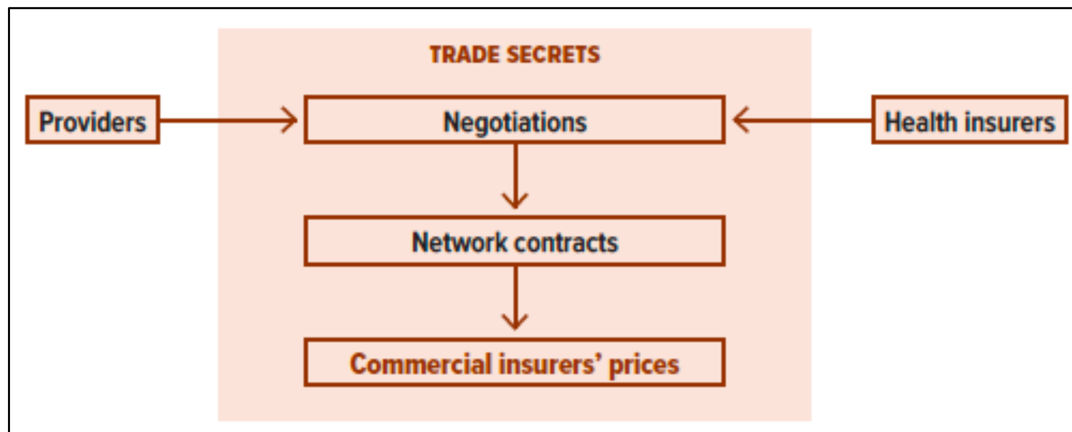
countries, governments act as "umpires" in the health sector, and they work to create policies that apply consistently across payers and sectors to moderate expenditure and target resources effectively.

Private Sector Pricing Models

The prevailing approach to pricing health care leads to prices that may have little, or sometimes almost no relationship, to the underlying cost of providing services. One analyst opined that "observers of markets outside of health care would be stunned by the degree of price variation" in health care.[13] While some price variation might be expected in different regions (due to living costs), these variations do not show any underlying logic. Price growth also appears unchecked and unrelated to changes in providing services: the average price to see a doctor in an emergency room visit for evaluation and management was $1,055 in 2019—an increase of 57% from 2012 to 2019.[14] Pricing strategies appear to lack coherence.[15] For example, hospitals' pricelists or "chargemasters" are rife with flaws, according to researchers. Duplicated items, errors, and multiple "prices" for a single item are examples of how services are priced in the U.S. health care system.[16] Prices paid vary even *within hospitals*.[17]

In other areas of the economy, higher prices denote higher quality, but in health care there is no relationship between higher prices and higher quality.[18] Analysts have opined that in any case, variation in prices is so large that "it is unlikely costs associated with differences in quality… would be as large as the differences in payment rates,"—instead, the main reason is that provider market power typically explains pricing variations.[19]

Figure 3 Stylized Illustration of How Commercial Insurers Determine Payments for Hospitals' and Physicians' Services



Source: Reproduced from the Congressional Budget Office, 2022[20]

Pricing discrepancies reflect the method used for setting prices. Private insurers negotiate prices with providers they would like to include in their networks. And in some cases, providers require insurers who want "must-have facilities" to contract with all facilities in a health system.[21] Though prices are secret, several factors influencing the prices negotiated between insurers and providers have been identified. These are summarized below in the Table 1. Notably, most are unrelated to underlying costs or geographic variations in costs. Organizational characteristics, such as practice affiliations with hospital networks are significant. Multi-specialty or specialty areas of medicine are at an advantage while primary care is at a disadvantage.

Table 1 Factors Influencing Negotiated Private Sector Prices (Physician Services)

Factors Associated with Price	
Provider concentration in the area	Lower fees where many providers; rural areas with fewer may receive higher fees
Number of insurers in state or county	More insurers in a market creates downward pressure
Hospital affiliation/ ownership	Prices increases after affiliation.
Specialty / Primary Care Practice	Primary care practices appear to have less negotiating power than specialty and multi-specialty clinics
All-or-nothing Clause	Require insurers to contract with all facilities in a health system if they select one.

Authors' analysis of studies of price variation and factors influencing price variation.[22]

The organizational structures of physician practices relative to the size and dominance of insurers drives differences in prices. Unfortunately, when service providers merge and consolidate, the result is the development of provider monopolies.[23] The tendency towards consolidation acts to increase provider prices. Nationally, MedPAC estimates that in 2019, private insurance payment rates for clinician services (across all service types) were 136 percent of traditional Medicare's rates, and this increased from 135 percent in 2018. They attribute the percentage point increase from 2018 to greater consolidation. In summary, pricing in the private sector demonstrates significant flaws, and prices of health care are likely to increase as consolidation increases--unless there is downward pressure on private prices.

Pricing Models in Medicare and Medicaid

Medicare's Fee Schedule and Medicare Payment Reforms

Medicare's payments are primarily based on the site of care, or where services are provided, as well as the nature of the service.[24] Here, we discuss only Part B or office-based physician and professional services, sometimes called "traditional" Medicare-which directly pays physicians and other professionals on a fee-for-service basis for each service provided.

Before 1992, Medicare paid providers the seventy-fifth percentile of usual, customary, and reasonable charges in an area.[25] Since its introduction in 1992, the Medicare Fee Schedule has become a de-facto national fee schedule. Private payers and other public programs also have adopted this system.[26] The Centers for Medicare and Medicaid Services administers the

schedule and makes updates to the schedule through rulemaking. Services are identified using the American Medical Association's proprietary Current Procedural Terminology (CPT) system. CPT codes are also known as "Level I" codes under the U.S. Healthcare Common Procedure Coding System (HCPCS). "Level II" codes include medical devices, durable medical equipment, prosthetics, orthotics, and supplies, as well as other drugs and biologics. The U.S. approach diverges from other countries, such as in France, where equivalent coding systems are typically in the public domain and owned by the government.[27]

Table 2 Components of the Resource-Based Relative Value Scale (RBRVS)

<table>
<tr><th>Relative Value Units (RVU)
(National)</th><th>Geographic Adjuster</th><th>National $ Conversion Factor (CF)</th><th>MACRA:
If physician participates</th></tr>
<tr><td>Physician Work Relative Value Unit (WRVU)</td><td>WRVU x WGPCI
Geographic Practice Cost Index</td><td rowspan="3">Sum of RVUs x
$ CF</td><td rowspan="3">$CF x %

e.g., A-APM
MIPS</td></tr>
<tr><td>Practice Expense Relative Value Unit (PE)</td><td>PE-RVU x PE GPCI
Geographic Practice Cost Index</td></tr>
<tr><td>Malpractice Cost Relative Value Unit (MP)</td><td>MP-RVU x MP GPCI</td></tr>
</table>

Key: Hospital Outpatient Department (HOPD); Ambulatory Surgical Care Centers (ASC) Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Quality Program Participation – Advanced Alternative Payment Models (A–APMs) Merit-based Incentive Payment System (MIPS)
Note: New Mexico is a single geographic zone for the Medicare GPCI

National payment levels for Medicare Part B services are published in the Medicare Fee Schedule and are derived from relative weights for each service. The weights are derived from a methodology called the resource-based relative value scale (RBRVS).[28] In theory, weightings reflect relative resource use associated with providing each service, measured in Relative Value Units (RVUs). Each of the 8,000 services in the Medicare Fee Schedule has different resource weights, one for physician work, one for practice expense value, and one for professional liability insurance, and these are multiplied by a Geographic Practice Cost Index (GPCI) weight for each. The GPCI reflects relative costs of physician work, practice expense, and malpractice expenses compared to the national average costs. New Mexico has a single GPCI, but some states have more than one GPCI. The total RVU is multiplied by the fee

schedule conversion factor, which is nationally set, and adjustments are made for quality metrics (see Table). The Conversion Factor turns these weights into a dollar payment.

Decisions on the RVU weights fall under the responsibility of CMS, however, CMS receives significant input from the American Medical Associations' Resource-Based Relative Value Scale Update Committee (known as RUC), which recommends weights to CMS. The RUC bases its recommendations on specialty societies' recommendations which are in turn derived from surveys filled out by specialty society members themselves.

Concerns have been raised about the extent to which this process produces accurate payments and whether it pays primary care services sufficiently: along with academic research, both MedPAC and the Government Accountability Office have critiqued the process used to develop the weights. There is particular concern that imaging, procedures, and surgical service weights can be driven up more easily because of the range of sub-specialty services that are less frequently billed, compared to the smaller range of billing codes available to non-procedural specialists.[29]

In addition, the extent to which the increases in relative weights are held in check is unclear. Historically, the weights used in the Medicare Fee Schedule were subject to "budget neutrality" adjustments and the conversion factor was also adjusted according to a formula that tracked growth in Gross Domestic Product, among other factors. Due to political pressure from physician organizations, adjustments were jettisoned under in 2015 by the Medicare Access and CHIP Reauthorization Act (MACRA). MACRA replaced cost-oriented penalties with "merit-based incentive payments" (MIPS) and alternative payment systems (APM) that are incorporated into the formula today.

These problems do not just affect Part B services, but ripple across Medicare services because the Medicare Fee Schedule is used by Medicare payment systems for visits, procedures, imaging, and surgery in hospital outpatient and ambulatory surgery settings.[30] RVUs are used in the Outpatient Prospective Payment System (OPPS) which bundles services' work and malpractice insurance weights. In turn, payments for services in Ambulatory Surgical Centers (ASC) are paid based on a percentage of the OPPS payment.

Despite these known flaws in the fee schedule, overall, Medicare has contained costs more effectively over time than private insurance payers and has generally negotiated lower rates than private insurance. Medicare's almost universal use has made it an attractive system for other payers to adopt. Using Medicare as a basis for pricing is becoming more widespread by other payers, particularly those moving towards more standardized pricing approaches. In Montana, 35,000 state employees are now receiving services based on a Medicare rate.[31] Oregon's public 12 employee plan pays hospitals up to 200 percent of Medicare rates for

inpatient services and 185 percent for outpatient services.[32] Since January 2021 Washington has required fees to be no more than 160% of the total amount Medicare would have paid for the same services, and primary care service payments must be at least 135% of Medicare.[33] The Colorado Health Insurance Option also applies Medicare's hospital rates, and its base rate for hospitals is 155% of Medicare rates.[34]

Reforms to Medicare Payments

As mentioned, providers can receive extra payments under payment reforms from MACRA and Medicare created Accountable Care Organizations. The term "Accountable Care Organization" (ACO) dates to 2006.[35] Medicare has been developing other ways of paying providers in the decade since the Affordable Care Act was passed by paying providers for services using the Medicare Fee Schedule and other Medicare payment systems under bundled fees. ACOs are designed to save money and improve quality by providing financial incentives to providers for "integrating" a range of health services and information systems. ACOs are one of a variety of "value-based purchasing" and other pilot projects supported by the Center for Medicare and Medicaid Innovation (CMMI). Many of these models still rely on bundling prices of existing services. Unlike the classic HMO, ACO members are not restricted to the providers within an ACO. In fact, patients do not necessarily know an ACO is financially "accountable" for their care. They will therefore be able to use providers outside the ACO organization.

Substantial reductions in health care spending have not materialized, though the concept continues to evolve. Indeed, a recent study found that "when bonuses CMS paid to ACOs are subtracted from gross savings, the programs lost money or saved no more than a few tenths of a percent."[36] One issue is that an ACO's benchmark is reset to its most recent level of spending every three years. As a result, "lower spending [is] penalized with lower subsequent benchmarks" and undermines the incentives to reduce spending.[37] Unlike more successful managed care organizations, ACOs do not receive their care within one organization, and are not dominant providers in their communities. This makes systemic change more challenging when the benefits are unlikely to spillover to other payers and providers. ACO-like organizations could result in future savings, and may bring other benefits that are not measurable, but the evidence to date on costs is less conclusive.[38]

Medicaid

Nationwide, Medicaid programs pay physicians approximately 72 percent of Medicare rates, on average.[39] New Mexico Medicaid rates are 90 percent of Medicare, on average. Primary care fees are 78 percent of Medicare fees, obstetric care services are 98 percent, and other services are 1.05 percent of Medicare fees in New Mexico.

Medicaid fee schedules (and other state health insurance programs) are heavily influenced by the Medicare Fee Schedule. State programs' fee schedules are typically either based on Medicare RBRVS relative values, a percentage of Medicare's fees, or state-developed using a combination of factors.[40] When updating payment rates, the New Mexico Department of Human Services uses a combination of Medicare and RBRVS, changes in the Consumer Price Index (CPI), a market basket analysis, and rates in neighboring states (Colorado, Arizona, Texas, and Oklahoma).[41]

Table 3 Fee-for-Service Pricing Models used by Medicaid and State Payers

Payment Model	Payers
Modified or Equal to Medicare Fee Schedule*	Medicaid (23 states). Workers' compensation programs
Percentage of Medicare Fee Schedule/ Minimum or Cap	Medicaid (15 states) Montana State employees Washington State public option
State-determined schedules	Medicaid (12 states) Workers' compensation programs
New Mexico	Medicare rates; changes in the CPI; market basket of services; neighboring states' updates

Source: Authors' analysis; New Mexico Human Services Department Fiscal Year 2021 Budget Request Factsheets Medicaid and CHIP Payment and Access Commission 2017.[42]

Key: Resource-Based Relative Value Scale (RBRVS) * Payers may change conversion factor and/or relative value units to arrive at prices

Medicaid Managed Care Organizations (MCOs) negotiate payment rates with providers. In New Mexico, MCOs must pass on the payment increases in the fee-for-service fee schedule, according to the New Mexico Department of Human Services.[43]

Part II: Best Practices from High-Achieving Health Systems

1: Multi-Payer Models Are Feasible

As originally conceived, the HSA envisaged a more unified model of health insurance coverage that would encompass the private and public sector programs. This type of approach is often described as a "single payer" health care system,[44] though so-called single-payer systems are diverse in terms of institutional arrangements: some countries using this approach operate a single government-run insurer (for example, Taiwan for the whole country, or Canada for each province). Other single payer systems, such as the UK National Health Service (NHS) go a step further and incorporate publicly owned and operated services (usually mainly in the hospital sector) or payments to outpatient private services, rather than insurance-based financing.

One of the strongest arguments for a single payer approach to health insurance is that it maximizes the pooling of risk. While this is a persuasive argument, international experience suggests that creating a single payer system is not the *only* way to pool risks. Many other countries with universal health insurance pool risk without depending on a single-payer model. Austria, Belgium, Germany, France, Japan, the Netherlands, and Switzerland instead rely on a system of multiple insurers. Unlike private insurance in the United States, these countries with multiple insurers operate within more constraints about what they can charge, based on the risk of their pool. Premiums are often subsidized for the poor (or directly provided by a government insurance program) and they are more standardized.

In contrast to NHS systems, multi-payer systems tend to rely on dedicated payroll taxes that are collected by the Government, and then paid to insurers, rather than via employers, as occurs in the U.S. and more like Medicare's financing. Many countries have successful multi-payer systems, and their experience suggests countries can pool risk broadly and reduce administrative costs by regulating insurers and creating consistent policies for the entire healthcare sector. A common feature of both systems is their focus on affordability and protection for those with chronic conditions and/or high utilization.

Multi-payer systems are characterized by a more balanced public-private mix than in single-payer systems, though they still tend to be financed through "social" insurance systems. In these multi-payer systems, health insurers are not government-owned, however, they are regulated more like a public utility. There are multiple payers for the provision of essential benefits under basic coverage (France, Germany, Belgium, Netherlands, Switzerland, Japan).

Some of these countries (Germany, the Netherlands and Switzerland) even encourage private insurers to compete within a set statutory framework that regulates basic coverage benefits, sets standard fee schedules, and (with few exceptions) allows access to all providers. Indeed, there is often an important role for the private sector to play in offering supplementary private health insurance. Individuals also contribute to the funding of health care through out-of-pocket payments.

Across the countries we have examined, provider networks tend to be broad, and except for a few managed care options in Switzerland, few of the health funds that compete in Germany, the Netherlands or Switzerland exclude providers from their networks. The benefit packages do not vary as much as in the United States. In Switzerland, the premiums for health plans with comparable packages vary substantially across and within cantons, but the benefit packages themselves or the level of out-of-pocket payment do not vary as much as the plans offered through the New Mexico marketplace.

Single-payer and multi-payer systems abroad both achieve comprehensive population-wide coverage of their populations. Multi-payer systems tend to be slightly higher cost than single payer systems. Both are lower cost because they pay hospitals and health care providers lower fees than in the United States Countries do not necessarily leverage efficiencies by having a single insurer for all. Instead, employees and others remain in plans that are organized (typically though not exclusively) via occupational groups or sectoral employment. Governments standardize payment rates and coverage rules: all insurers are bound to pay uniform rates to the same providers.

International evidence suggests that relying on multiple payers does not imply enrollment challenges or a lack of choice. Germany, the Netherlands, and Switzerland all provide their residents with choice of several health insurance plans (in Switzerland, for example, "the average person has a choice of 59 insurers"[45]) and have annual open enrollment periods that are comparable to the ACA. These countries apparently enroll people in plans without difficulty.

The challenge in the United States' fragmented insurance market is whether to develop standardized provider rates for all providers regardless of payer, or concentrate on provider rates just within a smaller group of payers? One model in the United States is Maryland, which has the longest record of operating a state hospital rate setting program, with its shift to this model in 1974. Maryland's Health Services Cost Review Commission (HSCRC) has seven volunteer commissioners appointed by the governor. It establishes rates for all inpatient, hospital-based outpatient, and emergency services in the State. It makes annual adjustments that account for medical cost inflation and changes in case mix. Since 1977, HSCRC has established Medicare and Medicaid rates as well.[46] Although the hospital cost growth, per

admission, in Maryland has been below the national average since 1976, and is one of the lowest in the country,[47] the system is limited because it does not include hospital-based physician costs.[48]

In 2014, CMS approved Maryland's revised Medicare payment system, which was designed to "test the ability of all-payer hospital population-based payment models to reduce hospital expenditures while maintaining or improving the quality of care."[49] Thus Maryland intended quality targets designed to promote better care, better health, and lower costs. Under the model, hospital quality and population health measures regarding the quality of care received by Maryland residents—including Medicare, Medicaid, and CHIP beneficiaries—improved.

Subsequently, in 2019, a new waiver was signed with CMS moving to a truly "all payer" model for hospitals, whereby Maryland is exempted from using Medicare payment rates under the Inpatient Prospective Payment System (IPPS) and the Outpatient Prospective Payment System (OPPS), with rates set by the State. In addition, all third parties agree to accept the same rate. All-payer per capita total hospital cost growth is limited to 3.58 percent, the 10-year compound annual growth rate in per capita gross state product.[50]

2: Prices are Standardized and Held to Budget Targets

International models, and some domestic examples, illustrate how health care systems develop specific institutional arrangements to implement standardized pricing across payers and create budget caps. These arrangements are overseen by government under a formalized statutory framework, which is tied to overall health care spending targets.

For example, in Japan, the Prime Minister working with the Ministry of Finance, sets a global budget for health care spending and determines the rates of increase that is consistent with country's economic goals for the budget. Within the cap established by the prime minister, the Japanese Ministry of Health then sets physician fees and hospital rates in negotiation with providers.[51] Thus revision occurs at the global budget cap and item by item.[52] (Ikegami, 2014). Like U.S. physicians in private practice are paid on a fee for service basis under a national fee schedule. The Dutch Health Care Authority, funded by the Ministry of Health, has its own governance structure, and plays a comparable role as an independent authority in the Netherlands.[53]

In France, Parliament sets annual budget targets,[54] the Ministry of Health sets case-based reimbursement rates for public and private for-profit hospitals, alike, and the NHI Fund for Salaried Workers (on behalf of France's other two national funds for agricultural workers and the self-employed) negotiates payment rates with physicians' representatives. In Germany,

associations of health-insurance funds negotiate with hospital and physicians' associations on an annual basis. This bargaining takes place within the context of a fixed budget cap and the physicians' unions bargain among their respective specialties to set the value of their fee schedules. In all these cases, a standardized payment system operates within some sort of budget restraint.

While such approaches may seem very different from those used in the U.S., in fact the U.S. attempted to model payment policies for Medicare based on international models.[55] Though Congress stopped short of the kind of budget-minded structure with balanced representation of all stakeholders, these ideas did influence the design of the Medicare Part B payment rates.

As the chair of the Medicare Payment Advisory Commission (MedPAC) testified, instead of basing fees on "input costs," Medicare physician payments should instead reflect the "value of the service and the price needed to ensure an adequate supply."[56] Alternatively, prices can be determined based on a negotiation and the consideration of what is achievable within resource constraints. As Ikegami and Anderson put it, "If the United States wishes to contain health care spending, it should rethink the basic assumption that providers should be compensated for their costs" and pay fees relative to what the country can afford."[57] In practical terms, when prices are standardized, they are designed to align with the cost of providing them. Therefore, "the price needed to ensure an adequate supply" is paramount, even if there is disagreement on the "true" cost of providing the service. In most high-income countries, countries pay physician fees based on annual negotiation, and create standardized pricing that simplifies the transaction costs associated with the administration of the health care system.

A reasonable question is whether a standardized payment approach can work in an individual state. While implementing a single payer system is unlikely without major change to federal law,[58] the evidence suggests that there is considerable scope for standardized pricing. In Germany, rates are negotiated at the subnational level to allow for regional variation. More importantly, several other states including Maryland, Massachusetts, New Jersey, and New York have historically implemented some form of single payment rate regulation, though these efforts have all focused only on hospitals.[59] Overall, the literature on these state systems concluded that they resulted in lower hospital prices compared with states that did not use them.[60] In most states, however, hospital rate setting efforts were abandoned because the political champions that helped to establish them lost power, and the hospital industry worked to eliminate them.[61]

There are some notable examples of states trying to limit cost growth, for example, Rhode Island's Office of the Health Insurance Commissioner (OHIC) adopted affordability standards. The affordability standards require price controls that included inflation caps and diagnosis-based payments on contracts between commercial insurers and hospitals and clinics.

Specifically, it capped the annual price inflation equal to the Medicare price index, plus 1 percentage point for both inpatient and outpatient services, transitioned hospital payments from a per-diem to value-based payments and increased the share of spending on primary care services by 1 percentage point per year from 2010 to 2014. A study of this system found that fee-for-service spending in Rhode Island decreased by $76 per person (about 8%) due to these changes.[62] Although these reductions are modest, they are impressive in the context of overall health care inflation in the U.S.

Similarly, spending targets have been introduced in Vermont to cap cost growth by using a 5-Year Cost Growth Target related to economic growth. Health care spending is tracked over 5 years with the goal of keeping the average increase in costs to 3.5% – and no more than 4.3% – between 2018 and 2022. The caps were introduced in the context of Vermont's Green Mountain Care model, which is a voluntary network of health care providers that agree to be accountable for the care and cost of a defined population of patients. It is not an "all-payer" model, but it is comprehensive. Unlike conventional Medicare ACOs, the state forms an ACO and includes population health initiatives that serve Vermonters regardless of insurance or ACO participation. Finally, the model also integrates Medicaid into the All-Payer ACO Model using a Section 1115(a) Medicaid demonstration. The effort also involves increasing access to primary care, reducing deaths from suicide and drug overdose, and lowering the prevalence of chronic disease.

3: Fee-for-Service Payment Models Are Widespread

In most OECD countries, most physicians working in physician offices, are paid on a fee-for-service basis. Yet, a common perception regarding the U.S. health care system is that fee-for-service payments are to blame for its high costs, since providers are paid more for "doing more." The logic is straightforward and convincing. If a physician receives an additional payment for every service they provide, they have an incentive to provide more services, regardless of whether the marginal benefit of the additional service is greater than the marginal cost. To be sure, economists have documented examples of "supplier-induced demand," and find that it can lead to the provision of more services or more intensive treatment. In response to these concerns, managed care emerged to phase out fee-for-service physician payment and achieve greater efficiency of resource allocation and health system performance.[63] This decentralized approach encouraged efforts to develop innovative organizational forms of health care delivery and financing —for almost fifty years.[64]

As said above, expenditure on health care is the total volume or quantity of services multiplied by the price. This makes price and volume useful tools for controlling expenditures. However, in theory, decreases in the price of services may simply lead to providers seeing more patients. One concern associated with the implementation of a standardized payment system is that

providers will respond to any restrictions in the growth of prices by increasing the volume of care.[65] In fact, some argue that there is "substantial evidence that when faced with reductions in price, providers would respond with increases in the number of services they deliver."[66] In contrast, the U.S. CBO reports that, "a decline in the amount that a provider is paid would generally be expected to result in fewer services being delivered." That type of response has been observed in skilled nursing facilities and home health agencies, and there is some evidence that it occurs in hospitals."[37] Physicians' services could be different, and in some cases, doctors induce further demand to offset the effects of fee constraints, meaning that 25-30 percent of the savings are lost.[67] They may shift their practices towards services that offer higher reimbursement.

Other countries that use negotiated prices have identified efforts by physicians to increase volume and take a variety of steps to combat it.[68] But the perceived failures of fee-for-service may be less important than holding absolute prices steady.

4: Administrative Costs Can be Lowered

High-performing health systems keep administrative costs low. Administrative complexity adds significant costs and hassle for patients, providers, and payers. For patients, the impact of administrative costs is tremendous administrative burden. And this typically falls on those least able to weather the impact of gaps in enrollment coverage and/or access to services.[69]

Although some administrative spending is necessary to make the health system function well and be responsive to patients and clinicians, administrative costs that reflect unnecessary complexity, taking away resources that could go towards patient care, lower premiums, and other valuable services that contribute to better health care. Higher administrative costs can also be a symptom, to some extent, of a payment system or insurance approval system in need of streamlined approaches.

Over the past quarter-century, a variety of studies have reported on the payer side of administrative spending. A 2014 study concluded that the U.S. spends about twice as much per capita on health care administration than Canada, France, Germany, the Netherlands, England, Scotland, or Wales.[70] OECD data indicate payer-side administrative costs of 5.3% for Germany, 4.7% for Switzerland, and 3.5% for Netherlands, compared to 7.1% for the United States, though this is an average of private and public sector costs and likely undercounts the overall system costs. U.S. administrative costs associated with commercial health insurance *only* are, on average, 12-15% of premiums.[71] In 2007, the McKinsey Global Institute (MGI) compared the United States to other wealthy nations with universal coverage.[72] MGI found that "administration and insurance" spending by U.S. payers in 2003 was nearly six times as

much as the OECD average due to our system that relies on multiple payers with multiple reimbursement rules and rates. In addition, while adjusting for GDP, MGI concluded that the U.S. spent $477 billion more than its "Estimated Spending According to Wealth" (ESAW).

Box 1 Administrative Costs in Canada, Germany, and Switzerland

Canada
The Canadian insurance system has lower administrative costs than the U.S. because there is only one payer in each Canadian province in comparison to over 1000 payers in the U.S. However, it is important to remember that administrative costs in Canadian hospitals are also lower because hospitals are largely funded by global budgets. This contrasts with case-based and fee-for-service payments (within broad budget targets), as in most other nations today. As a result, we should not expect that the full amount of Canadian savings could be realized in New Mexico with full "single-payer" implementation unless New Mexico chose to reimburse hospitals via fixed global budgets. More realistically, New Mexico should look to Germany, Netherlands, or Switzerland, which have hospital payment mechanisms that require elements of case-based reimbursement (as under the U.S. Medicare Program). This approach is both more realistic for New Mexico and could be accommodated, as it is in other countries, under a multi-payer single payment system.

Germany
Germany has a complicated insurance system, but a relatively straightforward two-level pricing system. Higher-income people are insured in the private sector insurance system, which is about ten percent of the population. Physicians serving the privately insured have a fee schedule, but it is not updated or regulated by the government. Thus, this creates greater billing complexity (though the providers appreciate higher fees) and this is a source of inequity in Germany. There are approximately 200 health insurance funds. In the period for which we have data, German health insurers were competing for members and there were costs of enrollment, disenrollment, and marketing. Although some funds do work to discourage riskier enrollees, Germany has a sophisticated risk-adjustment scheme applied through a national solidarity fund, which limits the consequences of risk-selection tactics.

Switzerland
The Swiss system also includes 80-90 funds that compete on quality and price, with regulations to guard against “cream skimming” of the lowest risk patients. There is a standard benefit package, but plans offer different levels of deductibles and co-insurance; and a few offer HMO-like options with restricted networks of providers.[73]

Other than a comparative study of the U.S. and Canada, which is an outlier due to its reliance on global budgets, estimates of provider-side differences in administrative costs between the U.S. and other countries are less common.[74] The calculation of Canadian administrative costs ($307 per capita, compared to $1,059 in the U.S.) is surely an underestimate in comparison to Switzerland, Netherlands and Germany since it does not control for differences between hospital payment rules.[75] Analysis of U.S. administrative costs (from 1999) shows per capita

spending for all hospital administrative costs ($315) were higher than payer-side costs ($259 per person for insurance overhead) and slightly less than the administrative costs incurred by all physicians and dentists ($324) [76]

The McKinsey Global Institute estimate mentioned above, which found that "administration and insurance" spending by U.S. is roughly six times as much as the OECD average, is far higher than the OECD figures for administrative costs because it includes a broader definition of administrative costs and includes provider-side savings as well as those on the payer side.

There is an increasing understanding of the impact of insurance and billing rules as adding to the costs of U.S. health care, however. One study on the physician component of provider-side costs is particularly illuminating: Casalino and colleagues found that the average U.S. physician spends 43 minutes a day interacting with health plans about payment, dealing with formularies, and obtaining authorizations for procedures.[77] A 2012 international survey by the Commonwealth Fund, puts this finding in perspective as it finds that among 11 countries, the share of physicians, or their staff in the U.S. (54%) reporting that the time they spend dealing with insurance plans to get patients needed care because of coverage restrictions is a major problem, was almost twice that of most other countries, e.g. France (20%), Netherlands (28%), Switzerland (24%) or Germany (41%).[78]

Of course, physicians' time spent in obtaining payment by insurers to cover their patients' needed care is only one component of the administrative costs associated with getting reimbursed by so many payers, each paying different prices and imposing different formularies and billing requirements on physicians. If we assume that the physician component of provider-side savings is equal to slightly over half of all administrative costs we would need to add the time that increasing numbers of non-clinical personnel in American hospitals spend dealing with numerous insurers. We would come close to doubling the estimate of provider-side savings—all of which would exceed payer-side savings estimates by OECD. In addition, none of these estimates account for all the time spent by Americans on insurance paperwork or disputes about medical bills.[79]

Part III: Recommendations for New Mexico

In the United States, studies of substantial price variation for hospitals and physicians with identical cost structures point to the fact the status quo approach—said to be a "market" determination of health care prices—is unrealistic as well as undesirable. In the context of the HSA this points to the need for a coordinated, rather than supposed "market" basis for prices. Prices in health care do not reflect conventional market processes.

While there is a diversity of health systems and institutional arrangements, most countries have sought to develop a set of uniform pricing mechanisms that balance provider, payer, and patient goals. There are benefits associated with aligning payment rates and practices, in areas where the State has jurisdiction, under a *multi-payer* financing model. Increasingly, U.S. states are doing just that and experimenting with pricing reforms, as well as reducing cost growth. Harmonizing provider payment rates is a key to significantly reducing administrative spending. In addition, various non-pricing changes are recommended that would encourage a sustainable health care system.

1. Standardize Health Care Pricing Using the Medicare Fee Schedule

A multi-payer model can achieve the three objectives of reform described at the beginning: universal coverage, rate regulation, and the simplification of health insurance administration. A multi-payer standardized payment system can control growth, especially if there are overall budget targets. Ultimately, a more integrated payment system also provides greater potential for addressing population health management.

Patients: would likely experience lowered out of pocket costs through access to providers they may not be able to afford, which would free family resources for other goods and services. Over the longer term there should be reduction in health care costs that will lower or stabilize premium growth. There are of course, potential uncertainties, including that the scope of the HSA, and the level of change that would occur. If the plan includes Medicaid, higher reimbursement rates would encourage more providers to sign up, and this would expand access for the almost 50% of individuals in New Mexico on Medicaid. Medicaid beneficiaries would benefit from having similar provider networks as privately insured individuals. The impact on patients would vary according to their baseline current access and according to the availability of state waivers for premium tax credits etc.

Providers: for many providers who currently bill rates close to average employer-sponsored rates, the impact of shifting to a standardized price may mean very little adjustment. Depending on the design of the policy a standardized fee schedule could increase payments for professionals who are in smaller or sole practices and lacking leverage with private payers, and those with more Medicaid patients. Lowered financial risks may transpire if enrollment policies and strengthened provider protections are enhanced. The standardization of prices would free up providers from negotiating with the payers included in the HSA. With improvement in contracting with the state providers may find it easier to serve a broader array of patients from state programs. With payment rules and preauthorization rules simplified and greater transparency on how to seek preauthorization and greater uniformity of billing, administrative costs and burdens should be reduced.

Payers and the Health Care System: a policy change such as this could improve access to primary care and reduce the use of more costly sites of care, lower administrative costs, and increase stability in the exchange market. There would be positive benefits for privately insured individuals and businesses. Private insurers may also accrue benefits from price standardization. According to Song 2019, insurers under the exchange would find local markets more predictable and insurers might stay in the marketplace in counties where they currently operate, as well as expand into more counties. Increased insurer entry would also boost competition between insurers. That produces lower premiums or enhanced benefits for consumers, according to Song.[80]

Adopt the Medicare Fee Schedule

We recommend adopting the Medicare Fee Schedule (with modifications) to provide standardized pricing. Leaving the "market" to determine provider rates in the United States has largely failed. In contrast to private payers, Medicare is more successful than private in tamping down costs: Per person private insurance growth increased between 2009-2019 by 3.6 percent, while Medicare's rate of growth per enrollee was 1.9, close to the inflation rate (1.8%).[81] Medicare has the most comprehensive network of physicians and other professionals despite participation in Medicare being voluntary, and this participation occurs despite limits on balance billing. Less than 1 percent of physicians opt-out of the program, and in 2020 only 54 physicians opted-out of Medicare in New Mexico, which is equal to the rate of active physicians opting out nationally (1%).[82] Once a physician has opted out, they cannot be reimbursed by Medicare, and they may not accept patients from Medicare Advantage (Part C) plans for two years.

Using the Medicare Fee Schedule creates efficiencies, given that physicians accept Medicare and are familiar with its pricing policies, thus "piggy-backing" on existing structures.

Using Medicare as a basis for pricing is becoming more widespread by other payers, particularly those moving towards more standardized pricing. Montana saved an estimated $47.8 million between 2017 and 2019 by switching to Medicare rates for some of its employee health insurance programs.[83] Oregon's public 12 employee plan pays hospitals up to 200 percent of Medicare rates for inpatient services and 185 percent for outpatient services.[84] Washington now requires fees to be no more than 160% of Medicare fees, and primary care fees must be at least 135% of Medicare.[85] The Colorado Health Insurance Option also applies Medicare's hospital rates, with hospitals using 155% of Medicare rates.[86]

Risks

There are disadvantages associated with the Medicare Fee Schedule. If payments are set too low, then providers may refuse to accept them. This is discussed below.

If New Mexico used Medicare's fee schedule as its benchmark the State's relative prices are determined by Medicare policymaking processes. Unfortunately, Medicare's price structure has been critiqued as over-paying for specialist medical services relative to primary care and misvaluing services.[87] This means that payment systems used by providers and payers in New Mexico will have to likely follow the changes made at the national level in terms of the frequency of updates (quarterly and annual changes) as well as coding changes incorporated into fee schedules at the national level.

To address this, it will be important to monitor coding and policy changes made by Medicare. New Mexico would need to ensure that the fee schedule biases against primary care reimbursement are addressed. One way to do this is through additional state payments to primary care providers. Flexibility may be needed so that the Commission can make volume-based adjustments.

Recommendation: The HSA should base payment rates on the Medicare Fee Schedule and build in flexibility to address volume increases.

Determine the Mix of Caps, Floors, and Rates

In New Mexico and in other states, policy makers have encountered resistance over proposals that standardize pricing across all payers.[88] The level of reimbursement is an important driver of participation, and thus it depends on how much scope there is to regulate prices across all payers under the HSA. However, there are different approaches to using the Medicare Fee Schedule.

One approach is to set a cap, which would ensure fees are no *more than* a maximum percentage rate of Medicare payment rates. Another approach is to use a cap and a floor, which is a minimum and maximum percentage rate. Minimum fees are helpful (1) for increasing the price of services currently undervalued, and/or (2) to prevent third parties from setting fees too low, for example in a managed care contract. Finally, rather than allow different providers to set different rates, a standard percentage of the price listed in the Medicare Fee Schedule for each service could be applied.

The impact on providers is market-specific and depends on the baseline rates negotiated with insurers, the composition of payers in a practice, as well as the nature of the benchmarks applied. Standardization of prices can bring up some payer rates while moderating outlier fees charged by a small percentage of providers. In most metro areas, private insurer negotiated prices are clustered between 100% and 130% of Medicare's Physician Fee Schedule. Employer-sponsored insurance rates for professional services average around 131% of Medicare in Albuquerque.[89] With the caveat that these estimates with regard to Albuquerque lack granularity, we use a data tool published by the Health Care Cost Institute to show the difference between Medicare, Medicaid, and private insurer rates for professional services. We simulated different payment rates using Medicare fees. Their estimates apply to employer-sponsored insurance plans.

According to the Health Care Cost Institute, each approach has slightly different effects, with the fixed percentage having the most widespread impact. However, the authors of the tool also caution that they cannot predict how many professionals would *increase* their fees, given a cap or a range approach. Different approaches and their estimated impact are summarized below.

1. **Rate Cap Based on Percentage of Medicare Rates**: This approach simply introduces a maximum rate. This would not create standardization per se, and might encourage providers to increase their fees to the cap. For a rate cap set at 160% of Medicare the estimate of the average change in professional fees in Albuquerque would be $0 (0% change).
2. **Price Ranges or Caps with Floors:** Fees cannot be less than a certain percentage of Medicare rates, or more than a percentage of Medicare rates. This gives providers more choices to set their rates, however, there is a risk that providers will increase their rates to the level introduced. With a Rate Floor at 120% of Medicare, and a Rate Cap at 160% of Medicare, the estimate of the average change in professional fees in Albuquerque would be $0 (0% change).
3. **Fixed percentage of Medicare Rates:** This approach has a larger impact under a rate setting policy than under a cap-and-floor policy. The fixed percentage approach is sensitive to the percentage level at which the rate is set at. At 140% of Medicare the average change in prices in Albuquerque would be $6, a change of 7%.

Table 4 Comparison of Medicare, Employer-Sponsored and Medicaid Rates for Professional Fees in Albuquerque, New Mexico (2018)

Payment Compared to Medicare (%)	100%	110%	120%	130%	140%	150%	160%
Medicare	$68	$75	$82	$88	$95	$102	$109
	Employer-Sponsored Insurance						
Average increase/decrease	(-$21)	(-$14)	(-$8)	($-1)	+$6	+$13	+$19
(%) Change	-24%	-16%	-9%	-1%	7%	14%	22%
	Medicaid						
(Absolute change)	+$15	+$22	+$29	+$35	+$42	+$49	+$56
(%) Increase over base fee	28%	42%	55%	66%	79%	92%	106%

Source: Authors' calculations, based on employer-sponsored insurance data from the Health Care Cost Institute[90] and Stephen Zuckerman et al.2017.[91]

Note: Medicaid base rate: $53. The Medicaid fees are shown as absolute changes rather than average changes.

Table 4 shows the base Medicaid rates in relation to the Medicare Fee Schedule rates, which would affect 954,491 people enrolled in Medicaid in New Mexico. Determining the level at which Medicare would pay providers requires additional data to measure the likely impact throughout the State. However, the financial impact is not the only factor in provider participation---introducing policies that support providers (non-financial incentives), is also important.

Recommendation: Assess the impact of different fee schedule benchmarks to determine feasible benchmarks for HSA.

Determine the Scope of Standardization Across Payers

Ideally, all payers in New Mexico would be subject to the same payment rules, even if they were not paying for care from the same pool of resources. Yet, in New Mexico and in other states, policymakers encountered resistance over proposals to standardize pricing across all

payers.[92] This is unfortunate, because regulating — (especially) private fees, is the most direct route toward a more streamlined and affordable health care system, however, there are several options. Another approach would be for New Mexico to simply adopt a statewide fee schedule. This is the approach that California legislators initially considered but abandoned.[93]

One of the most significant issues in regulating insurers, is the considerable segmentation of legal authority over the insurance market. Recent analysis by researchers at George Washington University and Foley Hoag and Elliot, [94] have outlined the parameters of encompassing federally funded programs and self-insured plans in more detail, so this is a short overview in relation to the implications specifically for payment policies.

Legal authority varies across public and private, and state and federal government, along with overlapping jurisdictions. The Federal government has jurisdiction over Medicare, the Medicaid program (jointly with the states), Affordable Care Act subsidies such as the coverage premium tax credit (APTC) and rules regarding benefits and coverage within private insurance. State Medicaid fee-for-service programs receive federal matching funding. State and local governments have their own programs for public employees and retirees which are funded and regulated by the states. This allows them to create a "public option," with ACA tax credits and other incentives contingent on federal approval.

Private individual insurance is both regulated at the state and federal levels. Employer-sponsored insurance has different rules depending on how the insurance is purchased. When firms purchase policies for their employees directly the insurers are regulated by the states. In New Mexico, 60 percent of firms in New Mexico "self-insure" by using private health insurance companies as intermediaries for claims and enrollment. The firms assume the risk for those employees. These plans are regulated at the federal level under the Employee Retirement Income Security Act (ERISA). This implies the following considerations if New Mexico decides to regulate via the contracts providers make with payers across different market segments.

Medicare Waivers: An all-payer rate-setting model encompassing Medicare would require waivers under a payment innovation program. Under the Social Security Act Section 1115, CMS may prioritize innovative payment models that replace or modify fee-for-service models, especially in primary care, so New Mexico would therefore need to consider developing ACO and other models. However, the Act specifically refers to all-payer models that encompass everyone in a state: "Allowing States to test and evaluate systems of all-payer payment reform for the medical care of residents of the State, including dual eligible individuals." In addition, the legislation specifies that waiver applications are assessed based on how much the innovation model "demonstrates effective linkage with other public sector payers, private sector payers, or statewide payment models."[95] The legislation refers to "statewide payment models" and this may imply that a waiver could be developed after a prior statewide payment

model. This suggests that New Mexico could apply for a waiver after developing a state-wide payment model. Section 402 waivers require additional investigation.[96]

Medicaid: The New Mexico Medicaid program covers about close to half of the population. The size of the Medicaid program in New Mexico means that, even if the insurance reforms involved only Medicaid and public employee plans, it would capture a large share of the health insurance market. Although the State cannot capture the benefits of a true "all-payer" rate setting program, due to ERISA, it can capture some–particularly when it comes to administrative costs. New Mexico currently contracts with MCOs for Medicaid, which pay providers. Bringing in the MCOs under stipulated pricing policies would help New Mexico move to a more streamlined system.

At a minimum, the State could explore modifications to MCO contracts with carriers and the standardization of rates, along with standardization of rules providers must conform to. Currently, around 83 percent of Medicaid enrollees in New Mexico already receive their care through private insurers that contract with the State based on fixed payments made to the insurers for the care provided for each enrollee. The State should determine the relationship between Medicare and Medicaid waivers for payment reform innovations, and/or if incremental modification of existing waivers should be requested. Part of this determination involves understanding whether Medicaid and a public option would be integrated or mirrored. Guardrails that are part of federal Medicaid demonstration law would make it challenging to modify Medicaid to more closely resemble the HSAP, because Medicaid coverage is more comprehensive. Waivers could be sought, however, that modify and improve primary care reimbursement or make other improvements that could align with the HSA plan design. Another alternative would be to develop a public option to mirror Medicaid, without changing Medicaid.

Exchange Plans/Federal Subsidies under the ACA: Section 1332 waivers can be used to redirect premium tax credits (APTCs) and federal pass-through payments that people could use to buy a public option.

State employee plans and regulated private insurers: These plans fall under the scope of the Office of the Superintendent of Insurance and allow provider rate setting. Taking this a step further, if the State creates a public option, the employee plans could be integrated, or the HSA and state employees could retain a separate but identical program. The plan could be offered as a buy-in option and in this area alone the State could engage in smart purchasing.

Self-insured firms: States jurisdiction over provider reimbursement rates when providers are contracting with self-insured plans is uncertain. It is unclear as to whether a rate-setting law applies: Recent decisions in the courts have led to speculation on the ability of ERISA to

circumscribe setting rates.[97] On the one hand, ERISA gives employers significant independence from state insurance regulation, on the other hand, ERISA does not alter states' power to regulate their insurance markets. A detailed analysis of waiver program options or ERISA law is beyond the scope of this analysis; however, we believe that there is potential to explore the ways in which payment policies relate to the "business of insurance." Alternatively, the State could offer the HSA as an *option* to self-insuring employers.

With these considerations in mind, we present a set of options (Table 5) showing varying levels of scope in terms of standardization of prices.

Table 5 All Payer Options for Price Standardization

Option	Insurers and Payers Included	Insurance Payers Excluded	Legal Considerations
Option 1: All Payer †	HSA State plans Medicaid, Medicare Commercial PHI	ERISA PHI	Medicaid and Medicare waivers Exchange subsidy waivers
Option 2: Under 65 All Payer††	HSA State plans Medicaid Commercial PHI	Medicare ERISA PHI	Medicaid waiver Exchange subsidy waivers
Option 3: State and Private Plans	HSA State plans Medicaid Commercial PHI	Medicare ERISA PHI	Medicaid waiver Exchange subsidy waivers
Option 4: State Plans	HSA, State plans Commercial PHI	Medicare Medicaid ERISA PHI	Exchange subsidy waivers

Key: Employee Retirement Income Security Act (ERISA); Private Health Insurance (PHI)

†All plans, per the HSA exclude Tricare and the Veterans' Administration.

†† Excludes Medicare-eligible who are 65 and over, and people under 65 covered by Medicare.

Note: "State" plans include exchange and state employee and state retirees.

Going forward, New Mexico policymakers should explore the opportunities available relating to payment innovation waivers. Federal Medicare waivers encourage alternative payment methods, and some states have all-payer demonstrations underway. With an emphasis on cost-containment this would meet the criteria for budget-neutrality required the federal government. However, even if this is not achieved immediately, a standardized payment system can begin to bring the benefits we have described in this paper.

Recommendation:

Standardized pricing should be adopted for state insurers and explored within the scope of waiver opportunities for programs such as Medicaid and Medicare.

Decide on Pricing Update Policies

Keeping fees updated is an important aspect of all payment systems, and typically updates apply either to the value of a service (in relative values), or in dollar terms (a conversion factor update). Updates are made to address changes in the underlying "cost" of providing the service. Fee updates can be left to the discretion of payers, be tied to other indexes, or negotiated between payers and providers. Indexes of price changes can be used to update fees for economy-wide increases in the cost of providing services that arise from general price inflation or medical price inflation. Changes to the service weights or relative value units may also shift if the "costs" of providing the service change, such as severity of patients seeking care or new technological innovations. Medicare adjusts these weights and adds new services to address these issues, based on advice from physician groups on the nature of the service.

The Act specifies that annual payment increases are to be no higher than the M-CPI. Service would therefore be allowed to increase to the extent of the M-CPI. This language would need to consider the meaning of "increase" in the context of the payment methodology used. The HSA could update fees in different ways:

- Use Medicare updates: i.e., use the same changes in the Medicare Economic Index and/or identical conversion factors
- Adjust the CMS conversion factor with reference to the M-CPI
- Follow CMS relative base weights only, and not the conversion factor
- Adjust growth depending on economic growth

Some states have growth targets, most notably, Massachusetts, and other states are also adopting this approach, including Delaware, which uses a target growth rate related to economic growth. The language of the legislation does not address the role of state resources in determining economic growth pr budgetary limitations in considering the rate of payment increases, but this could be added. To help control the volume of health care services, New Mexico could adjust fees for specific services for which there are significant volume increases. If the volume of a service increases more than expected, the price is reduced.

Finally, the legislation allows the Commission discretion to change fees under certain circumstances “based on a showing of special and unusual circumstances in a hearing before the commission.” There is a risk that this could open the Commission up to pressure to change pricing policies in response to stakeholders.

Recommendations:

Include language on update policies within the HSA relating to update processes and consider tying updates to economic growth, state budgets, or volume increases.

2. Develop Payment Policies to Incentivize Providers

While the scope of the HSA is not finalized, the policies recommended would support and improve the participation of providers in public programs, particularly Medicaid. Conversations with providers revealed systemic problems in the payment and coverage of services (across public and private payers) that are both important to providers and potential areas of opportunity for the State to improve provider participation.

Incentivize primary care physician participation

Under the Health Security Act plan enrollees would select a primary care provider. In Section 2(T) the bill defines primary care as a “physician, osteopathic physician, nurse practitioner, physician assistant, osteopathic physician's assistant, pharmacist clinician or other health care provider certified by the commission to provide the first level of basic health care, including diagnostic and treatment services; services delivered at a primary clinic, telehealth site or school-based health center; and behavioral health services if those services are integrated into the provider's service array.” The Commission would be responsible for developing policies around referral and access to specialist physicians.

The Commission is also charged with developing a plan during the transitional phase of implementation to develop more primary-care and preventive services to coordinate care. A key issue will be addressing provider shortages: In 2021, New Mexico has 239 Primary Care Health Professional Shortage Areas (HPSAs). Attention to primary care reimbursement would likely address the access to primary care providers and the availability of primary care appointments.

Stakeholders: primary care groups can play an important role in the evolving design of the HSA, since system transformation will require input and engagement of primary care providers themselves. The HSA has a robust consultative structure included in the legislation, and in addition, House Bill 67 (2021) established the New Mexico Primary Care Council. This organization could play an important role in coordinating better primary care services in New Mexico. The goal of the Council, which has 22 members from a range of organizations, is to lower the cost and increase the quality of primary care services, as well as to address the shortage of primary care providers.[98] In the mental health area, a mental and behavioral health services committee may provide input on how to strengthen mental healthcare, and regional councils can also inform policymakers on health care needs throughout the State.

Increasing reimbursements: The Commission could increase reimbursements to primary care physicians and nurse practitioners. This "bump" would apply to primary care physicians and nurse practitioners and modeled on the federal funding provided under the Affordable Care Act. A review found mixed effects of the fee bump, but several studies found positive effects of Medicaid fee increases on having a usual source of care [99] Similarly, states that boosted reimbursements under the saw increased appointment availability, and those states with the "largest increases in availability tended to be those with the largest increases in reimbursements"[100] One study investigated the effects of the ACA's Medicaid Primary Care Rate Increase, which used federal funds to increase Medicaid reimbursements for primary care services to Medicare levels during a two-year period, 2013–2014. They found that this Medicaid "fee bump" improved the use of prenatal care among non-Hispanic Black and White women.[101]

Mental Health: Investment in primary care services should also include mental health. HSA references behavioral health care in its discussion of primary care. Mental health care needs are increasingly integral for managing patients in the community. These providers have experienced historically lower rates of reimbursement. Providers in New Mexico told us there is a non-uniform distribution of mental health providers, and that children particularly experienced barriers to receiving care placed by managed care organizations. As of September 2021, New Mexico had around 1 million individuals living in Mental Health Care Health Professional Shortage Areas (HPSAs), and a need for an additional 74 providers.

Targeted reimbursement policies for primary care physicians: these may be necessary particularly if New Mexico adopts the Medicare Fee Schedule, since rates for primary care services in the Medicare Fee Schedule have been historically undervalued. In addition, the centrality of primary care under the legislation as the "first point of care" means these clinicians are important people in the new system. The State could set floors on primary care payment rates for physicians and nurse practitioners. Some states are pursuing permanent increases in primary care reimbursement. In Washington State, following the enactment of a state law that called for the creation of new public option plans, the Washington Health Benefit Exchange (HBE), in partnership with Health Care Authority (HCA) and Office of the Insurance Commissioner (OIC), created new public options, called Cascade Care that are sold through the individual ACA marketplace. Cascade Care sets *floors* on primary care payment. Primary care physicians may not be paid less than 135 percent of Medicare, and rural critical access hospitals or sole community hospitals not less than 101 percent of Medicare (allowable costs).[102] Cascade Care Select plans were first offered through the marketplace, Washington Healthplanfinder, in 2021.[103]

Patient-Centered Coordinated Medical Homes: New Mexico could look at other states' experience and continue to develop patient centered primary care medical homes.[104] Several of these include financial incentives for primary care physicians. A notable example is Rhode Island, which established its program in 2008. Health plans participate in the Care Transformation Collaborative of Rhode Island (CTC) (formerly the R.I. Chronic Care Sustainability Initiative (CSI-RI)). After starting with five sites, the Rhode Island program now includes 43 primary care practices, serving over 300,000 state residents. Assessments of the program indicate improvements in patient and provider satisfaction, health outcomes, and reduced ED and hospital visits.[105,106] Rhode Island increased its rate of payment by $3 per member, per month. These payments supplement existing fee-for-service payments and are linked to practice self-assessment and achievement of National Center for Quality Assurance's PCCMH standards. Though fee-for service payment is a widely used payment method, per-person flat payments or per-practice methods recognize the role that primary care physician roles extend beyond the face-to-face time they spend with patients. Without this recognition, the needs of patients with more complex needs and those who require care coordination may be less likely to be addressed.

Waivers: policymakers can consider how the possibility of waivers via Medicare and Medicaid might support the development of primary care payment innovations such as medical homes.

Recommendations:

Use formalized stakeholder structures to develop provider-driven changes

Increase primary care physician and nurse practitioner reimbursement

Explore feasibility of "floor" levels for primary care services, to ensure private insurers pay providers adequately

Support patient centered primary care medical homes and consider capitation payments

Explore how primary care medical homes could be part of a waiver for payment innovation

Incentivize HSA Participation by Eliminating Claw-Back Policies

One critical role for the State in a redesigned health care system is to ensure the system encourages procedures and practices that are fair and advance the needs of all participants in the State, not just payers. During stakeholder discussions, providers expressed considerable concern that they face onerous "claw backs" of fees, typically by Medicaid MCOs. Rather than pay providers patient by patient, payers increasingly have made offsets in their payments to providers if they determine that the provider should not have billed for an unrelated patient.

Of course, payments are sometimes made in error, and payers should be able to request providers return overpayments, and sometimes there may be small clerical errors or billing adjustments needed. However, significant, unforeseen, and automatic deductions are a different matter. Such adjustments also impact financial and tax reporting.

To encourage provider participation in the HSA plan, New Mexico should survey payers they contract with and provider associations, including the Primary Care Council,[107] to understand claw backs and determine the financial impact on providers. Medicaid Managed Care contracts and all other insurance contracts should be reviewed and adjusted if there is no provision to ban claw backs. The legal aspects of claw-backs, such as whether Medicaid MCO contracts with the State allow this, should be investigated. ERISA plans may or may not be subject to oversight, depending on how it relates to the business of insurance.

Recommendations:

Insurance practices such as claw-backs should be investigated across all insurance plans (including ERISA plans, if possible).

Review legislation, and if it is not possible under rulemaking, the State should amend the HSA legislation to eliminate claw backs

4. Simplify Health Insurance

International evidence indicates that a multi-payer system with a uniform set of payment rates can eliminate provider-side administrative costs as effectively as a single-payer system. The components of administrative complexity include prior authorizations, variation in billing rules across multiple payers, different rules such as services that cannot be provided on the same day, different rules for different plans offered by the same insurer, and others.

Our review of experience abroad leads us to believe that the administrative savings for both single payer and multi-payer single payment are similar, supporting the theory that standardized rates make a difference for providers and patients, providing certainty about the cost of health care. Estimating administrative cost savings is difficult, but the rationale for streamlining systems goes well beyond cost due to the inefficiencies it creates and the incentives it provides for providers to simply avoid contracts with payers. Based on estimates by the Congressional Budget Office, standardizing rates in a system with universal health insurance coverage reduces overhead expenses for providers "because collection costs would be lower if payment rates were uniform and the uninsured were covered."[108]

Develop Consistent Payment Rules

For decades, providers have complained they "must negotiate and then keep track of all the different prices from all the different plans they manage."[109] This increases administrative costs for providers and the wider system. Based on conversations with providers in New Mexico, many are frustrated by high administrative costs and hassles in their practice, and they are hopeful that the HSA can address their concerns.

If insurers adopt disparate rules for payment, the benefits of a common fee schedule would be eroded. Therefore, rules should be consistent and standardized. The Commission has an important role in setting policies that ensure rule uniformity in the fee schedule.

Recommendation:

The Commission should take an active leadership role in the State's efforts to unify payment rules.

The State should investigate incorporating a simplification strategy within a potential payment innovation waiver application.

Review Patient Insurance Verification Processes to Reduce Provider Financial Risks for Participating Providers

In New Mexico, simplifying the determination of eligibility, the administration of subsidies for health insurance, and improving the technical capacity of the plan will be crucial for improving the enrollment process. Currently, enrollment into the Medicaid program begins through a system called ASPEN, but enrollments to the state employee insurance program is separate from this system.

Single payer models are often favored for their administrative simplicity, which offer benefits in terms of being easily accessible for more vulnerable populations. Providers may be more willing to sign up with HSA if there is good program integrity around coverage. Providers can see patients and be confident their patients have current coverage. At present, providers are held liable if they serve patients ineligible for insurance. Providers should be held harmless for providing routine medical and mental health services if there are administrative barriers to determining coverage; particularly in primary care settings, insurance companies should inform practices when a patient enrolled with a particular practice is dropped or otherwise no longer has coverage.

While private employer-sponsored insured individuals and State employee plan enrollees typically have more stability throughout the year, other segments of the insurance market can be more unstable. For example, the Exchange and Medicaid programs have more "churn" (people moving into and out of plans, usually due to changes in eligibility and/or inability to pay premiums for exchange enrollees). This means that "churn" issues are more likely to be an issue for providers contracting with HSA plans. If providers must verify valid insurance, the cost of developing a pooled enrollment verification system that updates eligibility in real-time for services across all payers contracting with the State would increase provider confidence that they can serve patients without being at risk of not being paid. If a pooled

insurance coverage data-exchange were created, this could ultimately be extended to be consumer-facing.

Opportunities to streamline and enroll people in ways that integrate healthcare may also be explored in a payment policy waiver since enrollment processes appear to be one area states are encouraged to address.

Recommendation:

The State should explore how patient enrollment verification processes could be addressed to meet provider concerns in the design of the HSA enrollment system.

The State should explore how a strategy of enrollment simplification could support a potential waiver application.

Require Uniform Utilization Review and Pre-Authorization Policies

Under the Affordable Care Act, insurers were required to cover preventive services, eliminating the need for each patient and provider to determine eligibility for coverage of these services.

Streamlining systems would prevent the problem of providers needing to "deal with many different insurers, each with its own requirements for claiming reimbursement."[110] These requirements change and vary across plan type—even for the same insurer.

One approach is to request that all insurers contracting with the HSA or with the State that they adopt uniform utilization review and pre-authorization policies, as part of the contracting process. Insurers would develop common plans and would submit these as part of the contracting process.

The State could facilitate this process by bringing the stakeholders together to develop shared policies within a rulemaking process. These policies would need to be reviewed and changed periodically,

Taking this approach would reduce significant burdens on providers and patients for all state-funded contracts with managed care or other insurers. For plans regulated under ERISA, requiring insurers to adopt standard utilization and pre-authorization policies may or may not

conflict with ERISA. This approach could also be considered as a potential policy focus for an all-payer innovation application.

Recommendation:
Explore the feasibility of creating standardized preauthorization procedures for insurers operating in the State using rulemaking processes and investigate applicability to ERISA plans operating in the State.

4: Develop Evaluation Frameworks of Payment Adequacy

Long term sustainability of the HSA relies on an information base and governance structure that can address inevitable adaptations that are required in a dynamic and changing health care system. Most importantly, long term support for increased state oversight of health care requires public and provider trust in the government institutions with stewardship roles.

Appropriately, the HSA builds in oversight and performance data collection. HSA 295 Section 11-N requires a comprehensive plan for collecting data, including the availability, adequacy, and training of health care personnel; health care system costs and health care availability, utilization, and revenues; Section 11-S of the HSA 295 requires the Commission to report to the legislature annually on the operation of the HSA plan and potential improvements in the areas of access and quality. The HSA bill also requires data collection and monitoring of the impact of the health security plan on the State's provider community and the State's health care workforce. The HSA also requires the Superintendent of Insurance to create an external review process to deal with grievances of consumers.

Develop Measures of Payment Adequacy

Payment policy[111] success is measured through "payment adequacy," which uses two kinds of data, patient data on access to timely and appropriate sites of care, and provider indicators of provider acceptance and participation. In addition, comparisons are made to rates offered by other payors. Here, we review the kind of indicators and feedback included in the HSA and recommend specific indicators that could be adopted.

Regional advisory organizations included in the HSA are also important sources of information. They create a rich stakeholder feedback structure that is also geographically representative.

The State should use commonly utilized measures of access, as well as access to care and access to coverage under Medicaid.[112] New Mexico has a history of using metrics of this kind in its Medicaid program. For example, MCOs have been required to demonstrate the use of Community Health Workers, as well as the use of telemedicine for specialty care provided in rural and frontier areas.[113] The State could adapt indicators of access to care used by Medicaid Managed Care Organizations for use by the HSA plans. To assess access for Medicare enrollees, MedPAC uses telephone surveys to measure access, and compares trends in physician compensation.

Box 2 Payment Policy Performance: Payment Adequacy

Payment Adequacy
Patient Access • Physician and clinician supply relative to population • Maximum Appointment Wait Time (Days) for Routine Care • Maximum Appointment Wait Time (Days; for urgent care: 1 day) • Geographic accessibility or travel times to access care • Patients who have a usual source of care • Visit to a general doctor in the past year • Visit to a specialist visit in the past year • Delayed medical care in the past year • Availability of Tele-Health Services • Hospitalizations and ED visits for ambulatory care sensitive conditions • Problem finding a new provider (for those who sought one)[114] • Maximum Enrollees per Primary Care Provider (1500 patients) **Provider Participation and Rate-setting** • Pricing using a basket of commonly provided services • Provider satisfaction • Claims payment timeliness • Administrative burdens • Provider participation: % of physicians accepting HSA plan(s)[30] • Prices relative to preferred provider organizations (PPOs) for clinician services • Review of input price changes in Medicare Economic Index (MEI) • Review of trends in physician compensation **Feedback** • Stakeholder structures established to inform the Commission will provide frequent feedback on the operation of policies • Input from regional advisory organizations

Source: Authors' analysis

Hospital administrative data could also be used to examine rates of hospitalizations and ED visits for ambulatory care sensitive conditions. Though this indicator is frequently an indicator of system quality, it addresses payment problems. Hospitalizations and ED visits for ACSC are indicators of access to timely and appropriate primary care services, including specialty services for the management of chronic disease. Examples of such diagnoses include congestive heart failure, asthma, and diabetes. High rates of hospitalization for ACSC, among residents of an area, often reflect barriers to health care.[115,116,117,118] These data are already collected by the State and easily compared.[119]

The State should develop common standards and consider annual surveys to monitor payment timeliness across all plans, including private sector timeliness and provider satisfaction. Ensuring timely payment is a known factor influencing provider take-up in programs such as Medicaid and is critical for building support and acceptance of the HSA. Many states adopted payment timeliness legislation to hold private insurers to account. New Mexico should develop claims payments standards.

New Mexico could use data such as that from FAIR Health or Truven Health Analytics MarketScan Research Data to track and monitor price trends in the State for self-insured and other non-HSA plans. We recommend developing a basket of services that are the most billed services and tracking these annually.[120]

Data should be collected on all access and price indicators (even those not specifically under the jurisdiction of the HSA), because such data allows useful comparisons. Collecting and developing some of these indicators will require investments by the State, but it is important to recognize that some of these indicators (enrollees per PCP; hospitalizations and ED visits for ambulatory care sensitive conditions) could be measured using routinely collected data. Other indicators (percentage of physicians accepting HAS; wait times; questions about the use of care during the past year) would require a telephone or survey-based questionnaire sent to enrollees and/or “mystery shoppers.” The latter would represent a greater investment in monitoring.

Recommendation:

The Commission should design robust payment adequacy standards and identify data sources for these indicators. This may not require legislative change, as it likely is already within the scope of the Commission function,

Support "All Payer" Price Standardization and Claims Databases (APCD)

All-Payer Claims Databases are used in 19 states.[121] APCDs pull together claims data from all the payers operating in a state. These data help to promote price transparency and can be used, not only to inform patients, but as part of a rate setting process.[122] For example, to support its regulatory approach, Rhode Island has created an all-payer claims database (APCD) to promote transparency in pricing. Rhode Island is one of 18 states that operate an APCD with mandatory reporting for all payers regulated by the state, which excludes self-insured health insurance plans operated by large employers. In most states, APCDs provide information intended to promote consumer price shopping. For example, Maine and New Hampshire use data from their APCD to create consumer-focused tools designed to make residents and employers more aware of variations in provider prices so they can shop for better deals.[123]

Washington State, also a state that has been advancing all-payer rate-setting, also has an all-payer database. The WA-APCD contains pharmacy, medical and dental claims as well as eligibility information. It is the most comprehensive source of claims data in Washington, with more than 6 million covered lives from more than 50 commercial, Medicaid managed care, and Medicare Advantage plans, but excludes self-insured plan data. Databases in Oregon, Rhode Island, and Washington (to date) have not included Medicaid fee-for- service or Medicare fee-for-service expenditures.

Some states have attempted to compel the submission of data from self-insured firms. A 2016 Supreme Court case Gobeille v. Liberty Mutual Insurance Co. upheld the right of the employer and its insurance firm (Blue Cross Blue Shield) to keep these records from Maine.[124] This means APCDs are incomplete, for example under California's law, self-insured employers are not included. This means that California will not have pricing data for the largest employers in the state."[125]

New Mexico is in the process of setting up an APCD. As the Rhode Island example suggests, APCD systems may result in spending reductions by providing policymakers with better information about geographic variation in charges. However, standardized pricing is not dependent on the existence of an APCD.

Recommendation:

Continue investing in all-payer data bases and systems and to seek participation by ERISA (self-funded) plans either voluntarily or under state insurance regulation.

Appendix

Existing Insurance Coverage in New Mexico

Currently, around 20 percent of the population of New Mexico is covered by Medicare. Of those, around half are in Medicare Advantage plans.[126] Medicaid covers around 40 percent of the population, or more than twice as many people as Medicare in New Mexico.

Public employees and retirees receive coverage under the Interagency Benefits Advisory Council (IBAC). IBAC arranges contracts with private health insurers for employees of Albuquerque Public Schools (APS), New Mexico Public Schools Insurance Authority (NMPSIA), New Mexico Retiree Health Care Authority (NMRHCA, and State of New Mexico Risk Management Division (SONM).

Table A1 Health Insurance Coverage in New Mexico (Estimated)

Coverage	Legal Jurisdiction	Percentage of the Market
Commercial Insurance	State	8%
Self-funded/ERISA plans	Federal	12%
Uninsured	State	12%
Medicare	Federal	20%
Medicaid	State/Federal	40%
Exchange	State	2%
IBAC	State	7%
	Total*	95%

*Estimates of insurance coverage vary based on the survey and the categories included or excluded (such as how people with overlapping coverage are counted) so do not add up to 100%. These estimates therefore should be used with caution and are illustrative.

Source: Estimates based on data from CMS and Manatt Health Strategies LLC. 2018[127]

Table A2 State Funded or Regulated Programs

Type of Coverage	Share of population
Commercial Insurance	8%
Exchange	2%
IBAC	7%
Insurance Sub-Total	17%
Medicaid	40%
Uninsured	12%
Total	69%

Source: Estimated based on Manatt Health Strategies LLC. 2018

References

[1] See Chiquita Brooks-LaSure, Patricia Boozang, Hailey Davis and Ashley Traube, 2018. Evaluating Medicaid Buy-In Options for New Mexic. Manatt Health Strategies LLC. https://www.manatt.com/Manatt/media/Documents/Articles/Evaluating-Medicaid-Buy-in-Options-for-New-Mexico.pdf

[2] Laugesen, M.J. and Glied, S.A., 2011. Higher fees paid to U.S. physicians drive higher spending for physician services compared to other countries. *Health Affairs*, *30*(9), pp.1647-1656.

[3] Roberts, E.T., Mehrotra, A. and McWilliams, J.M., 2017. High-price and low-price physician practices do not differ significantly on care quality or efficiency. *Health Affairs*, *36*(5), pp.855-864.

[4] Joseph White. 2011. "Prices, Volume, and the Perverse Effects of the Variations Crusade," *Journal of Health Politics, Policy and Law* 36(4):775-790.

[5] Berwick, Donald P., and Andrew D. Hackbarth. 2012. "Eliminating Waste in U.S. Health Care," *Journal of the American Medical Association* 307(14): 1513-1516; and "Health Affairs Health Policy Brief: Reducing Waste in Health Care," (Dec. 13, 2012) http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_82.pdf.

[6] Gusmano et al. 2021.

[7] Steven Brill. 2013. Bitter Pill: Why Medical Bills Are Killing Us. *Time*. March 4: 16-55.

[8] Laugesen, M.J. and Glied, S.A., 2011. Higher fees paid to U.S. physicians drive higher spending for physician services compared to other countries. *Health Affairs*, *30*(9), pp.1647-1656.

[9] Joseph White. 2013. Cost Control After the ACA. *Public Administration Review*. 73(51): 524-533.

[10] Sherry Glied. 2001. Health Insurance and Market Failure Since Arrow. *Journal of Health Politics, Policy and Law*.

[11] Chernew, Michael E., Leemore S. Dafny, and Maximilian J. Pany. 2020. A Proposal to Cap Provider Prices and Price Growth in the Commercial Health-Care Market. The Hamilton Project: Brookings. https://www.brookings.edu/wp-content/uploads/2020/03/CDP_PP_WEB.pdf.

[12] Donald M. Berwick. 2011. Making Good on ACOs' Promise — The Final Rule for the Medicare Shared Savings Program. *NEJM* 365:1753-1756. DOI: 10.1056/NEJMp1111671.

[13] This study compared prices as a percentage of Medicare rates, and so accounted for the geographic cost differences by using reimbursements as a percentage of Medicare rates. Paul B. Ginsburg. 2020. Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power. *HSC Issue Brief 16* Center for Studying Health System Change.

[14] John Hargraves, Angela Pupino, Aditi Sen, Kevin Kennedy. 2021. Health Care Cost Institute. 2022. https://healthcostinstitute.org/emergency-room/ouch-new-data-reveals-er-spending-increased-by-52-from-2012-2019-with-patient-out-of-pocket-payments-increasing-by-88

[15] Whaley, Christopher M., Brian Briscombe, Rose Kerber, Brenna O'Neill, and Aaron Kofner. 2020. *Nationwide Evaluation of Health Care Prices Paid by Private Health Plans: Findings from Round 3 of an Employer-Led Transparency Initiative*. Santa Monica, CA: RAND Corporation. https://www.rand.org/pubs/research_reports/RR4394.html.

[16] Lu, A.J., Chen, E.M., Vutam, E., Brandt, J. and Sadda, P., 2020 Price transparency implementation: accessibility of hospital chargemasters and variation in hospital pricing after CMS mandate. *Healthcare* (Vol. 8, No. 3, p. 100443).

[17] Cooper, Z., Craig, S.V., Gaynor, M. and Van Reenen, J., 2019. The price ain't right? Hospital prices and health spending on the privately insured. *The Quarterly Journal of Economics*, *134*(1), pp.51-107.

[18] Whaley, Christopher M., Brian Briscombe, Rose Kerber, Brenna O'Neill, and Aaron Kofner. 2020. *Nationwide Evaluation of Health Care Prices Paid by Private Health Plans: Findings from Round 3 of an Employer-Led Transparency Initiative*. Santa Monica, CA: RAND Corporation. https://www.rand.org/pubs/research_reports/RR4394.html.

[19] This study compared prices as a percentage of Medicare rates, and so accounted for the geographic cost differences by using reimbursements as a percentage of Medicare rates. Paul B. Ginsburg. 2020. Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power. *HSC Issue Brief 16* Center for Studying Health System Change.

[20] From Congressional Budget Office. 2022. *The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services*. Washington: Congressional Budget Office
[21] Katherine L. Gudiksen, Erin C. Fuse Brown, and Johanna Butler. 2021. *A Tool for States to Address Health Care Consolidation: Prohibiting Anticompetitive Health Plan Contracts*. National Academy for State Health Policy.
[22] See Congressional Budget Office. 2022. *The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services*. Washington: Congressional Budget Office; Pelech, D., 2018. *An Analysis of Private-sector Prices for Physicians' Services*. Washington (DC): Congressional Budget Office; Roberts, E.T., Chernew, M.E. and McWilliams, J.M., 2017. Market share matters: evidence of insurer and provider bargaining over prices. *Health Affairs*, *36*(1), pp.141-148; Post, B., Norton, E.C., Hollenbeck, B., Buchmueller, T. and Ryan, A.M., 2021. Hospital-physician integration and Medicare's site-based outpatient payments. *Health Services Research*, *56*(1), pp.7-15; Scheffler, R.M., Arnold, D.R. and Whaley, C.M., 2018. Consolidation trends in California's health care system: impacts on ACA premiums and outpatient visit prices. *Health Affairs*, *37*(9), pp.1409-1416; Capps, C., Dranove, D. and Ody, C., 2018. The effect of hospital acquisitions of physician practices on prices and spending. *Journal of health economics*, *59*, pp.139-152.
[23] See Clark C. Havighurst & Barak D. Richman 2010. The Provider Monopoly Problem in Health Care. *Oregon Law Review* Vol. 89, 847.
[24] This means prices, and methodologies used to create them, vary significantly depending on whether the service is provided in hospitals, nursing homes, or ambulatory surgery centers.
[25] Davidson, Stephen M. 1982. *Journal of Health Politics, Policy and Law,* Vol. 6, No, 4 pp 703-717.
[26] See Laugesen, Miriam J. 2016. *Fixing Medical Prices: How Physicians are Paid*. Cambridge: Harvard University Press.
[27] Albaret, S., and M. Girardier. 1999. "Classification Commune des Actes des Professions de Santé (CCAPS)." *Le Courrier De L'Evaluation En Sante* 15: 19-20.
[28] See Laugesen, M.J., 2014. The resource-based relative value scale and physician reimbursement policy. *Chest*, *146*(5), pp.1413-1419.
[29] Langer, A.L. and Laugesen, M., 2019, December. Billing Codes Determine Lower Physician Income for Primary Care and Non-Procedural Specialties. In *Forum for Health Economics and Policy* 22, No. 2
[30] Medicare payments are used in federal programs such as TRICARE as well as in state programs, see below.
[31] Appleby, J. 2018. "Holy cow" moment changes how Montana's state health plan does business. *Kaiser Health News*, June 20.
[32] Liu, J.L., Levinson, Z.M., Qureshi, N.S. and Whaley, C., 2021. *Impact of Policy Options for Reducing Hospital Prices Paid by Private Health Plans*. Santa Monica: RAND Corporation
[33] Wynne, B. 2019. Public Option 1.0: Washington State Takes An Important Step Forward. *Health Affairs Blog*, May 1
[34] Brady, Michael. 2020. "Colorado Unveils Public Option Reimbursement Rates That Officials Say Will Help Hospitals Remain Profitable" *Modern Healthcare* February 25 https://www.modernhealthcare.com/payment/colorado-unveils-hospital-rates-its-public-option-plan
[35] The term was invented in a conversation between two health policy experts in 2006 and is most associated with the work of one of those experts, Elliot S. Fisher of Dartmouth. See Elliott S. Fisher, Douglas O. Staiger, Julie P.W. Bynum and Daniel J. Gottlieb. 2007 "Creating Accountable Care Organizations: The Extended Hospital Medical Staff," *Health Affairs* 26, no. 1 w44-w57.
[36] Kahn, J.G., Sullivan, K.R. 2022. "Promise vs. Practice: the Actual Financial Performance of Accountable Care Organizations." *J Gen Intern Med* 37, 680–681. https://doi.org/10.1007/s11606-021-07089-6
[37] McWilliams, J. Michael and Alice Chen. 2020. Understanding the latest ACO "savings": Curb your enthusiasm and sharpen your pencils – Part 1. USC-Brookings Schaeffer On Health Policy. Thursday, November 12, 2020. https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/11/12/understanding-the-latest-aco-savings-curb-your-enthusiasm-and-sharpen-your-pencils-part-1/
[38] Marcia Gold. 2012. "Accountable Care Organizations: Will They Deliver?" op. cit.; Robert A. Berenson and Marcia A. Burton, "Next Steps for ACOs," *Health Affairs Health Policy Brief* (Jan. 31, 2012). http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_61.pdf.
[39] Stephen Zuckerman, Laura Skopec, and Marni Epstein. 2017. "Medicaid Physician Fees after the ACA Primary Care Fee Bump," Urban Institute. Available at:
[40] Medicaid and CHIP Payment and Access Commission (MACPAC). 2017. *Issue Brief: Medicaid Physician Fee for Service Payment Policy*. Washington DC: Medicaid and CHIP Payment and Access Commission.
[41] New Mexico Human Services Department *Fiscal Year 2021 Budget Request Factsheets*.

[42] Medicaid and CHIP Payment and Access Commission (MACPAC). 2017. *Issue Brief: Medicaid Physician Fee for Service Payment Policy*. Washington DC: Medicaid and CHIP Payment and Access Commission.
[43] "In general, managed care plans are not required to follow Medicaid fee-for-service rules for making Medicaid payments to providers" Medicaid and CHIP Access and Payment Commission. 2017. *Federal Requirements and State Options: Provider Payment*. Medicaid Access https://www.macpac.gov/wp-content/uploads/2017/03/Federal-Requirements-and-State-Options-Provider-Payment.pdf
[44] The term "single payer" does not refer to universal coverage but is a designation of whether a single (government) entity is the dominant insurer in the country. Commonly it refers to a system where a good proportion of the healthcare sector is also owned by the program financing healthcare, though this is not necessarily always the case.
[45] Ewout vn Ginneken, Katherine Swartz and Philip Van der Wees. 2013. "Health Insurance Exchanges in Switzerland and the Netherlands Offer Five Key Lessons for the Operations of U.S. Exchanges," *Health Affairs* 32(4): 744-752.
[46] Karen Wagner. 2011. "Maryland's all-payer system: a delicate balancing act," *Health Care Financial Management*, November: 112-116.
[47] NCSL. *Health Cost Containment and Efficiencies: NCSL Briefs for State Legislators*, June 2010.
[48] Wagner 2011.
[49] Robert Murray. 2014. Maryland's Bold Experiment in Reversing Fee-For-Service Incentives. *Health Affairs* http://healthaffairs.org/blog/2014/01/28/marylands-bold-experiment-in-reversing-fee-for-service-incentives/; accessed on February 28, 2022.
[50] CMS 2022. https://innovation.cms.gov/innovation-models/maryland-all-payer-model
[51] Joseph White 2013: 527.
[52] Ikegami, Naoki. 2014. Controlling Health Expenditures by Revisions to the Fee Schedule in Japan
[53] Cathy Schoen, David Helms, and Amanda Folsom. 2009. *Harnessing Health Care Markets for the Public Interest: Insights for U.S. Health Care Reform form the German and Dutch Multipayer Systems*. New York: The Commonwealth Fund and AcademyHealth, December.
[54] Isabelle Durand-Zaleski. 2010. "The French Health Care System, 2009," in *International Profiles of Health Care Systems*. New York: Commonwealth Fund, 2010: 23.
[55] See Laugesen, *Fixing Medical Prices*.
[56] Glenn M. Hackbarth. 2007. "Testimony: Options to Improve Medicare's Payments to Physicians." Statement Before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives. MedPAC, May 10, 2007.
[57] Naoki Ikegami and Gerard F. Anderson. 2012. "In Japan, All Payer Rate-Setting Under Tight Government Control Has Proved to Be an Effective Approach to Controlling Costs," *Health Affairs* 31: 1049-1056 (quote: 1p.055).
[58] Rosenbaum et al. 2022.
[59] New York was the first state to implement hospital rate regulation and that system continued, with some modifications, until 1997. See Robert Murray. 2012. "The Case for a Coordinated System of Provider Payments in the United States," *Journal of Health Politics, Policy and Law* 37(4): 679-695.
[60] Kenneth Murray and Robert A. Berenson. *Hospital Rate Setting Revisited Dumb Price Fixing or a Smart Solution to Provider Pricing Power and Delivery Reform?* The Urban Institute, 2015.
[61] Murray and Berenson 2015.
[62] Aaron Baum, Zirui Song, Bruce E. Landon, Russell S. Phillips, Asaf Bitton, and Sanjay Basu. 2019. Health Care Spending Slowed After Rhode Island Applied Affordability Standards to Commercial Insurers. *Health Affairs* 38:2, 237-245.
[63] Alan C. Enthoven. 1986. Managed competition in health care and the unfinished agenda. *Health Care Financing Review*, (Spec No), 105–119.
[64] Brown, Lawrence D. 1983 *Politics and Health Care Organization: HMOs as Federal Policy*. Washington DC: The Brookings Institution.
[65] NCSL 2010; Mark Pauly and Robert Town. "Maryland Exceptionalism? All-Payers Regulation and Health Care System Efficiency," *Journal of Health Politics, Policy and Law* 37(4): 697-707.
[66] William C. Hsiao, K.T. Li, Steven Kappel, Jonathan Gruber and colleagues. *Act 128 Health System Reform Design Achieving Affordable Universal Health Care in Vermont*, February 17, 2011.
[67] CBO (United States Congressional Budget Office), Key *Issues in Analyzing Major Health Insurance Proposals*. (Washington, DC: Congressional Budget Office, 2008) quote p. 109; see also Medicare Actuaries, "Memorandum: Physician Volume & Intensity Response (Aug 13, 1998), http://www.cms.gov/Research-

Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/PhysicianResponse.pdf; Technical Review Panel on the Medicare Trustees Reports. *Review of the Medicare Trustees' Financial Projections* (December 2000) op. cit. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/TechnicalPanelReport2000.pdf.

[68] Gusmano et. al. 2021.

[69] Pamela Herd and Donald Moynihan, "How Administrative Burdens Can Harm Health," *Health Affairs Health Policy Brief,* October 2, 2020. DOI: 10.1377/hpb20200904.405159

[70] Himmelstein, David U., Miraya Jun, Reinhard Busse, Karine Chevreul, Alexander Geissler, Patrick Jeurissen, Sarah Thomson, Marie-Amelie Vinet, and Steffie Woolhandler. 2014. Administrative Costs In Eight Nations: U.S. Costs Exceed All Others By Far. *Health Affairs*. https://doi.org/10.1377/hlthaff.2013.1327

[71] Deloitte Consulting LLP. 2013. *Health Insurance Market Overview: State Public Health Leadership Webinar*, August 15.

[72] McKinsey Global Institute. 2007. *Accounting for the Cost of Health Care in the United States*. San Francisco: McKinsey& Company, January.

[73] Claire Daley and James Gubb 2013. *Health Care Systems: Switzerland*. CIVITAS: NHS; Robert E. Leu, Frans F. H. Rutten, Werner Brouwer, Pius Matter, and Christian Rutschi. 2009. "The Swiss and Dutch Health Insurance Systems: Universal Coverage and Regulated Competitive Insurance Markets," Commonwealth Fund Report. January, 2009. One of the mysteries in the international statistics is why the Dutch system, which seems at least as complicated as the German and Swiss systems, is sometimes reported as having lower overall payer administrative costs (as in Nicolle and Mathauer op. cit.).

[74] Woolhandler, S. et. al. 2003. "Costs of Health Care Administration in the United States and Canada." *NEJM* 349: 768-75.

[75] *Op cit. #20*

[76] *Op cit. #20*

[77] Casalino et. al. What does it cost physician practices to interact with health insurance plans? *Health Affairs, 2009. 28: w533-w543.*

[78] Cathy Schoen, et. al. 2013. Access, Affordability, and Insurance Complexity are Often Worse in the United States Compared to Ten other Countries. *Health Affairs* 32 (12): 2205-2215, Exhibit 5.

[79] David U. Himmelstein, Miraya Jun, Reinhard Busse, Karine Chevreul, Alexander Geissler, Patrick Jeurissen, Sarah Thomson, Marie-Amelie Vinet, and Steffie Woolhandler. 2014. A Comparison of Hospital Administrative Costs in Eight Nations: U.S. Costs Exceed All Others by Far. *Health Affairs*, 33(9):1586–94

[80] Song, Z., 2017. Using Medicare prices—toward equity and affordability in the ACA marketplace. *New England Journal of Medicine*, *377*(24), pp.2309-2311.

[81] MedPAC 2021. *Report to The Congress: Medicare Payment Policy*. Washington DC: Medicare Payment Advisory Commission.

[82] Ochieng, Nancy, Karyn Schwartz, and Tricia Neuman. 2020. How Many Physicians Have Opted-Out of the Medicare Program? Kaiser Family Foundation. Available at: https://www.kff.org/3fe555d/

[83] Steve Schramm and Zachary Aters. 2021. *Estimating the Impact of Reference-Based Hospital Pricing in the Montana State Employee Plan.* Available at: https://www.nashp.org/wp-content/uploads/2021/04/MT-Eval-Analysis-Final-4-2-2021.pdf

[84] Liu, J.L., Levinson, Z.M., Qureshi, N.S. and Whaley, C., 2021. *Impact of Policy Options for Reducing Hospital Prices Paid by Private Health Plans*. Santa Monica: RAND Corporation

[85] Wynne, B. 2019. Public Option 1.0: Washington State Takes an Important Step Forward. *Health Affairs Blog*, May 1

[86] Brady, Michael. 2020. "Colorado Unveils Public Option Reimbursement Rates That Officials Say Will Help Hospitals Remain Profitable" *Modern Healthcare* February 25 https://www.modernhealthcare.com/payment/colorado-unveils-hospital-rates-its-public-option-plan

[87] Laugesen, Miriam J., Roy Wada, and Eric M. Chen. 2012. In Setting Doctors' Medicare Fees, CMS Almost Always Accepts the Relative Value Update Panel's Advice on Work Values *Health Affairs* 31: 965-972; S.A. Schroeder & W. Frist. 2013. Phasing out fee-for-service payment. *The New England Journal of Medicine,368*(21), 2029-32; S. Zuckerman, T. Waidmann, R. Berenson., & J. Hadley. 2010. Clarifying sources of geographic differences in Medicare spending. *The New England Journal of Medicine, 363*(1), 54-62.

[88] Sparer, M., 2020. Redefining the "public option": lessons from Washington State and New Mexico. *The Milbank Quarterly*, *98*(2), p.260.

[89] Health Care Cost Institute 2020. https://healthcostinstitute.org/hcci-research/how-differences-between-commercial-medicare-professional-service-prices-could-result-in-different-policy-impacts-1

[90] Health Care Cost Institute 2020. https://healthcostinstitute.org/hcci-research/how-differences-between-commercial-medicare-professional-service-prices-could-result-in-different-policy-impacts-1
[91] Laura Skopec, and Marni Epstein, "Medicaid Physician Fees after the ACA Primary Care Fee Bump," Urban Institute, March 2017;
[92] Sparer, M., 2020. Redefining the "public option": lessons from Washington State and New Mexico. *The Milbank Quarterly*, *98*(2), p.260.
[93] Via Associated Press. 2018. "California bill would create healthcare price controls" *Modern Healthcare* https://www.modernhealthcare.com/article/20180410/NEWS/180419998/california-bill-would-create-healthcare-price-controls
[94] For a thorough legal analysis of the bill, see Sara Rosenbaum, Morgan Handley, Thomas Barker, Ross Margulies, Haider Andazola, Alexander Somodevilla, Regina DeSantis. 2022. "An Analysis of New Mexico's Health Security Act: Moving Forward within the Current Federal Legal Landscape," Report to the New Mexico Superintendent of Insurance.
[95] See: Social Security Act Sec. 1115A [42 U.S.C. 1315a] https://www.ssa.gov/OP_Home/ssact/title11/1115.htm
[96] Please see the discussion on Section 402 by Sara Rosenbaum, Morgan Handley, Thomas Barker, Ross Margulies, Haider Andazola, Alexander Somodevilla, Regina DeSantis. 2022. "An Analysis of New Mexico's Health Security Act: Moving Forward within the Current Federal Legal Landscape," Report to the New Mexico Superintendent of InsuranceSection 402 see https://www.ssa.gov/OP_Home/comp2/F090-248.html
[97] "… the [Supreme Court's] *Rutledge* decision appears to signal that states may regulate the rates that health care providers and other entities charge for drugs or other items and services covered by ERISA plans." States cannot "compel plans to offer a certain type of coverage or administer benefits in a particular manner." The key question is whether a policy regulates health care costs, alternatively violates ERISA because a law would "dictate plan choices" See Jennifer A. Staman 2021. Supreme Court Decision Sheds Light on State Authority to Regulate Health Care Costs. Washington DC: Congressional Research Service. Available at: https://crsreports.congress.gov/product/pdf/LSB/LSB10587
[98] New Mexico Primary Care Council. 2021. Meeting Presentation October 27, 2021. https://www.hsd.state.nm.us/wp-content/uploads/FINAL-PCC-PPT2021_10_27.pdf
[99] Saulsberry, L., Seo, V. and Fung, V., 2019. The impact of changes in Medicaid provider fees on provider participation and enrollees' care: a systematic literature review. *Journal of General Internal Medicine*, *34*(10), pp.2200-2209.
[100] Polsky, D., Richards, M., Basseyn, S., Wissoker, D., Kenney, G.M., Zuckerman, S. and Rhodes, K.V., 2015. Appointment availability after increases in Medicaid payments for primary care. *New England Journal of Medicine*, 372(6), pp.537-545.
[101] Li, J., Pesko, M. F., Unruh, M. A., & Jung, H. Y. 2019. Effect of the Medicaid Primary Care Rate Increase on Prenatal Care Utilization Among Medicaid-Insured Women. *Maternal and child health journal*, *23*(11), 1564–1572. https://doi.org/10.1007/s10995-019-02804-6.
[102] https://www.hca.wa.gov/assets/program/cascade-care-one-pager.pdf
[103] https://www.hca.wa.gov/about-hca/cascade-care
[104] CDC. State Law Fact Sheet: A Summary of State Patient-Centered Medical Home Laws, In Effect May 2016. https://www.cdc.gov/dhdsp/pubs/docs/SLFS-PCHM-508.pdf
[105] https://www.pcpcc.org/it/initiative/care-transformation-collaborative-rhode-island-ctc
[106] Yeracaris, Pano, Susanne Campbell, Mardia Coleman, Linda Cabral, Debra Hurwitz. 2019. Care Transformation Collaborative of Rhode Island: Building a Strong Foundation for Comprehensive, High-Quality Affordable Care. *Rhode Island Medical Journal*. June: 26-29. http://www.rimed.org/rimedicaljournal/2019/06/2019-06-26-imsc-yeracaris.pdf
[107] New Mexico Primary Care Council. 2021. Meeting Presentation October 27, 2021. https://www.hsd.state.nm.us/wp-content/uploads/FINAL-PCC-PPT2021_10_27.pdf
[108] http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/76xx/doc7652/91-cbo-039.pdf
[109] Joseph White. 2013. "Cost Containment after the ACA," *Public Administration Review* 73(S1) 524-533.
[110] CBO, "Universal Health Insurance Coverage" op. cit., p. xiii.
[111] The overall level of insurance coverage and health care system quality is beyond the scope of this analysis
[112] See Sommers, B.D. and Kronick, R., 2016. Measuring Medicaid physician participation rates and implications for policy. *Journal of Health Politics, Policy, and Law*, *41*(2), pp.211-224.
[113] Bailit Health. 2020. State Strategies to Promote Value-Based Payment Through Medicaid Managed Care, Final Report. MACPAC. March 13. https://www.macpac.gov/wp-content/uploads/2020/03/Final-Report-on-State-Strategies-to-Promote-Value-Based-Payment-through-Medicaid-Mananged-Care-Final-Report.pdf

[114] The question asked is: "In the past 12 months, have you tried to get a new [primary care physician] and if yes, the respondent is asked "How much of a problem was it finding a primary care provider/specialist who would treat you?" MedPAC 2021. *Report to The Congress: Medicare Payment Policy*. Washington DC: Medicare Payment Advisory Commission.

[115] Mazurenko, Olena, Shen, Jay, Shan, Guogen, Greenway, Joseph, 2018. Nevada's Medicaid expansion and admissions for ambulatory care-sensitive conditions. *The American Journal of Managed Care* 24(5), e157–e163.

[116] Peters, GA, Ordoobadi AJ, Cash RE, Wong ML, Avillach P, Camargo CA. Association of Affordable Care Act Implementation with Ambulance Utilization for Asthma Emergencies in New York City, 2008-2018. *JAMA Netw Open*. 2020;3(11):e2025586.

[117] Mondesir, F. L., Kilgore, M. L., Shelley, J. P., Levitan, E. B., Huang, L., Riggs, K. R., Pisu, M., Li, Y., Bronstein, J. M., Agne, A., & Cherrington, A. L. (2019). Medicaid Expansion and Hospitalization for Ambulatory Care-Sensitive Conditions Among Nonelderly Adults With Diabetes. *The Journal of Ambulatory Care Management* 42(4), 312–320. https://doi.org/10.1097/JAC.0000000000000280.

[118] Gusmano, M.K., V.G. Rodwin and D. Weisz. 2006. "A New Way to Compare Health Systems: Avoidable Hospital Conditions in Manhattan and Paris," *Health Affairs* 25(2): 510-520.

[119] The New Mexico Department of Health Hospital collects this data via the Inpatient Discharge Database (HIDD)

[120] Neprash, H.T., Wallace, J., Chernew, M.E. and McWilliams, J.M., 2015. Measuring prices in health care markets using commercial claims data. *Health Services Research*, *50*(6), pp.2037-2047.

[121] Elizabeth Hinton, Lina Stolyar, Madeline Guth and Mike Nardone. 2022. *State Delivery System and Payment Strategies Aimed at Improving Outcomes and Lowering Costs in Medicaid.* Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/state-delivery-system-and-payment-strategies-aimed-at-improving-outcomes-and-lowering-costs-in-medicaid/

[122] Diaz-Perez, M. J., Hanover, R., Sites, E., Rupp, D., Courtemanche, J., & Levi, E. 2019. "Producing comparable cost and quality results from all-payer claims databases." *The American Journal of Managed Care,* 25(5), e138–e144.

[123] Robert A. Berenson, Jaime S. King, Katherine L. Gudiksen, Roslyn Murray, and Adele Shartzer 2020. *Addressing Health Care Market Consolidation and High Prices: The Role of the States*. Urban Institute.

[124] See https://www.supremecourt.gov/opinions/15pdf/14-181_5426.pdf
And Fuse Brown, E.C. and King, J.S., 2016. The Consequences of Gobeille v. Liberty Mutual for Health Care Cost Control Policy. *Health Affairs Blog:* https://www.healthaffairs.org/do/10.1377/forefront.20160310.053837/full/

[125] Gudiksen, K.L., Brown, T.T., Whaley, C.M. and King, J.S., 2018. California's drug transparency law: navigating the boundaries of state authority on drug pricing. *Health Affairs* 37(9), pp.1503-1508

[126]Centers for Medicare and Medicaid Services. 2022. Monthly Enrollment by State [CSV file] https://www.cms.gov/research-statistics-data-and-systemsstatistics-trends-and-reportsmcradvpartdenroldatamonthly/monthly-enrollment-state-2022-02

[127] Manatt Health Strategies LLC. 2018. *Evaluating Medicaid Buy-in Options for New Mexico* [Presentation Powerpoints] https://tinyurl.com/4shzy3tj