

# Reducing Administrative Costs in New Mexico's Health Care System

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**Miriam Laugesen, PhD**  
Associate Professor of Health Policy and  
Management  
Mailman School of Public Health  
Columbia University

**Julius Chen, PhD**  
Assistant Professor of Health Policy and Management  
Mailman School of Public Health  
Columbia University

# Overview

1. Acknowledgements
2. Introduction and study scope
3. Prior authorization and policy recommendations
4. Credentialing and policy recommendations
5. Conclusion and next steps

# Acknowledgements

- Participants of our interviews, who generously gave their time to share their views and information, we are most grateful
- New Mexico Legislative Council Services for sponsorship of this project.
- LHHS Committee leaders and staff

## Acknowledging a loss....

We want to acknowledge a tremendous loss that occurred a few months ago: Ms. Mary Feldblum, of Health Security for New Mexico.

Mary worked to improve the access and affordability of health care in the State of New Mexico. We were deeply impressed with her tenacity and enthusiasm. She showed a deep curiosity and thirst for understanding of the problems and solutions in health care.

# Study scope, history, and next steps

**Aim 1:** To identify significant administrative burdens in hospitals and independent medical practices in New Mexico. Two areas: billing- and insurance-related (BIR): **prior authorization** and non BIR, which includes **credentialing**.

Data Sources: Peer reviewed prior authorizations and credentialing from researchers, data from Office of the Superintendent of Insurance; AAPPR Physician Credentialing Report 2024; organizations concerned with prior authorizations and credentialing

Interviews with 22 key informants, Spring 2026:

- A cross section of New Mexico provider, payer, government, and nonprofit organizations, including three national organizations associated with credentialing and/or developers of credentialing software

**Aim 2:** To identify and describe solutions available internationally and nationally.

**Aim 3:** To develop policy recommendations for New Mexico

**Prior work:** Interim results presented November 2025.

**Next steps:** Input from LHHS; Final report (June 30); dissemination

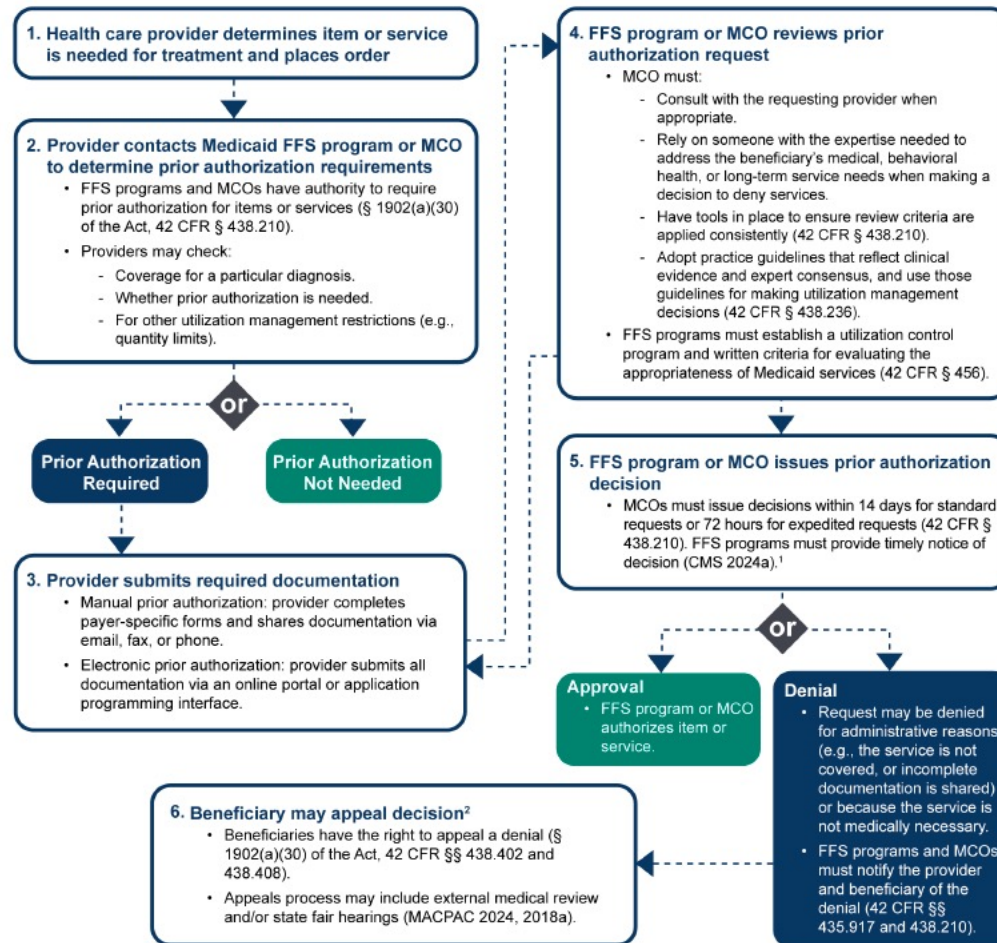
# 1. Prior Authorization

## Background on prior authorization

- Prior authorization (preauthorization, prior approval, or precertification) is a *utilization management* process that requires healthcare providers to obtain approval from a patient's insurer before they can provide a specific treatment, item, or medication.
- A broad scope of services can be included: inpatient hospital services, outpatient surgeries and elective procedures, rehabilitation and skilled nursing services, advanced diagnostic imaging, and prescription drugs.
  - Services commonly reviewed in New Mexico: magnetic resonance imaging (MRI) scans, follow-on hospital care, physical therapy, colonoscopy, and oral diclofenac for low back pain (OSI 2023).

# Medicaid Approaches

FIGURE 1. Current Medicaid Prior Authorization Process for Medical Services and Items



Source: MACPAC 2024

# Prior authorization advantages and impacts

- **Advantages:**
  - To limit unnecessary service utilization
  - Ensure that care provided is effective, relative to the cost of care
  - To encourage clinically appropriate care, e.g. compliance clinical guidelines (e.g. pediatric attention-deficit/hyperactivity disorder)
- **Disadvantages**
- Varies by patient populations, payers, and services:
  - Example: reduced spending for lipid-lowering medications (Lu et al. 2011)
- Can reduce timely access to essential services and quality of care.
  - Example: new prescriptions for oral anti-cancer medications delayed (Lichtenstein et al. 2021)
- May influence treatment choices, if burdensome processes are associated with certain treatments → health outcomes

## Regulatory framework in New Mexico

- The New Mexico Office of the Superintendent of Insurance (OSI) has the authority to regulate the utilization management practices of health insurers, collect data on prior authorization statistics, and ensure compliance with the Prior Authorization Act of 2019. Insurers must:
  - Submit a uniform prior authorization form through an online portal.
  - Provide data on prior authorization statistics.
  - Comply with outlined timelines for determinations.
- OSI reviews insurers' prior authorization practices each year to ensure that they promote lower cost and better quality and safety, but their enforcement authority is **limited to the commercial fully insured market**.
  - Information is useful however, even if enforcement is limited, but agencies also need resources to analyze and monitor the information

# Current New Mexico Timelines for Request Determinations Vary by Urgency and Service Type

Prior Authorization Type	Maximum Time
Medical Standard/Non-Urgent	7 Days
Medical Urgent/Expedited	24 Hours
Prescription Drugs Standard/Non-Urgent	3 Days
Prescription Drugs Urgent/Expedited	24 Hours

Note: If a determination is not made within the outlined timelines, the request will be automatically granted.

- Recent legislation has also prohibited or limited prior authorization for specific services, treatments, and conditions:
  - Emergency care [SB 188, signed in 2019]
  - Prescription drugs to treat “rare diseases or conditions” [SB 39, signed in 2025]
  - Prescription drugs to treat “an autoimmune disorder, cancer, a rare disease or condition, a serious mental illness or a substance use disorder” [SB 20, signed in 2026]
- The New Mexico Legislature’s efforts build upon federal efforts to streamline and increase accountability for prior authorization processes, such as the 2024 Centers for Medicare and Medicaid Services (CMS) Interoperability and Prior Authorization Final Rule.

## Analysis of OSI data

- The following tables present our analyses of prior authorization data reported to OSI by insurers for plan year 2021.
- Data is posted online, available [here](#).

## Prior Authorization (PA) Denial Rates, by Market, Plan Year 2021

	Commercial, Fully Insured	Marketplace	IBAC	Medicaid Managed Care
Total number of PAs requested (n)	73,511	11,164	29,201	306,295
Total number of PAs denied (n)	16,038	2,980	2,761	67,706
Overall, PAs denied (%)	<b>21.8%</b>	<b>26.7%</b>	<b>9.5%</b>	<b>22.1%</b>
<b>Denials, by care type</b>				
Prescription drugs	44.4%	39.5%	22.7%	45.4%
Inpatient physical health services	9.6%	30.1%	0.89%	5.2%
Outpatient physical health services	14.3%	19.4%	10.5%	16.8%
Outpatient mental health and substance use disorder treatment	25.8%	55.6%	3.8%	25.2%

## Processing Time Performance for Prior Authorization (PA) Requests, by Market, Plan Year 2021

<b>Prior authorization completion times, all service types</b>	<b>Commercial Fully Insured</b>	<b>Marketplace</b>	<b>IBAC</b>	<b>Medicaid Managed Care</b>
Non-urgent, completed within 7 days	83.0%	99.4%	74.1%	90.2%
Urgent/ emergent, completed within 24 hours	79.3%	95.2%	70.6%	91.0%

## Key findings from OSI 2023 Prior Authorization Report

- OSI 2023 Prior Authorization Report (for plan year 2023 data from fully insured plans):
  - Blue Cross Blue Shield-NM had the highest overall approval rate (81%)
  - United Healthcare of New Mexico had the lowest overall approval rate (53%)
  - Timeliness of Processing: Lower Performance:
    - Western Sky Community Care: for standard and urgent inpatient and outpatient care requests
    - Cigna: for standard and urgent prescription drug requests

## Recommendation Prior Authorization PA 1

- **Recommendation PA1:** OSI and HCA might coordinate efforts to conduct annual evaluations of prior authorization data.
- Careful analyses can uncover concerning trends (e.g., specific carriers having above average denial rates or decision turnaround times) and inform joint efforts to enforce broad insurer compliance with regulations, mandated decision timeframes, and patient protections.

## Key findings from stakeholder interviews: Theme PA1

- **Theme PA1:** There is a sharp contrast between the payer and provider perspectives on prior authorization.

Insurers view prior authorization as a necessary tool to promote patient safety, efficacy/appropriateness of treatment, and cost discipline.

**vs.**

Provider organizations view prior authorization as an obstacle to providing high-quality, timely, accessible, and responsive patient care.

## Key findings from stakeholder interviews, especially provider organizations (cont.)

- Reduces provider autonomy and limit flexibility in clinical decision-making.
- Requirements vary significantly across carriers (both within and across markets) and from year to year.
- Creates significant labor and operating costs.
  - Disproportionately negative impact on smaller and rural practices, hospitals, and FQHCs, which are often under-resourced.
- Prior authorization requests are often processed by numerous third-party agencies.
- A related friction between payers and providers involves the use of emerging technologies, such as AI, to facilitate prior authorization processes.

## Key findings from stakeholder interviews: Theme PA2

- **Theme PA2:** Legislation modifying the scope of prior authorization, as well as subsequent development and implementation of guidelines by state agencies, are important tools that balance payers' desire to maintain cost discipline with the need to protect patient access to timely care. However, their scope and impact can be improved through continued research and consideration of diverse stakeholders' input.
- Both payer- and provider-side interviewees expressed a desire for iterative refinement of agency guidelines outlining specific services that are exempt from prior authorization.
- Disconnect between the drafting of legislation and the interpretation, development, and implementation of regulations can lead to guidelines that are interpreted too narrowly by insurers or cause confusion among providers.

## Recommendation Prior Authorization PA 2

- **Recommendation PA2:** Current and future guidelines limiting prior authorization for specific sets of services or conditions should be periodically evaluated and iteratively refined to enhance effectiveness.
- For example, if future legislation aims to limit prior authorization for diabetes treatment, OSI and HCA might conduct regular analyses of insurer compliance; solicit feedback from payer, provider, and patient groups; and apply their findings to modify the guidelines (e.g., identify and publish specific diagnosis codes that are exempt from prior authorization, specify that prior authorization can only be applied to treatments that exceed a certain cost threshold).

## State models to watch

- HB 736 in Virginia → Requires insurers to honor initial authorizations for at least 6 months and continued authorizations for at least 12 months.
- SB 5395 in Washington → AI algorithms can be used to approve prior authorizations but not deny requests without a health professional's review.

## Key findings from stakeholder interviews: Theme PA3

**Theme PA3:** Legislative action and policy implementation must include and involve New Mexico Medicaid, which covers an estimated 38% of the state's population.

**Recommendation PA3:** Future legislation and guidelines modifying the scope of prior authorization should apply to Medicaid, in addition to the fully insured market.

- Engaging Medicaid in efforts to reform prior authorization is critical to supporting rural healthcare delivery and timely access among New Mexico's most vulnerable and underserved populations.

# 2. Credentialing

# Credentialing

The process of obtaining and verifying information about a provider and evaluating that provider:

- Clinical credentialing: when individual clinicians work for organizational provider of health care (e.g. hospital or health system). Requires verifying and onboarding physicians (e.g. CVs, references, procedure logs, applications, and verifications).
- Insurance credentialing: when clinicians and organizational providers want to join an insurance network.

Requires exchange between two parties: clinician and provider; and clinician and provider to the insurer

*Recredentialing* renews or updates the credential.

# The need for credentialing

- Verification and oversight protects patients and institutions from unqualified or ineligible clinicians
- Ensures a patient is selecting in-network care that is covered by their insurance and that claims will be processed/paid

## Reducing friction and delays in credentialing is important, because the workforce/care supply **impacts access**

- Expanding the number of people and organizations providing health care increases access
  - Reducing delays in the approval of clinicians and providers increases the supply of available care
  - Better processes may incentivize people to stay in the workforce longer or work part-time rather than retire or quit
  - Making it easier to work in New Mexico – whether fulltime, temporarily, partial year, or permanently, increases workforce supply.

# Interviewees stressed the fact that the term credentialing is shorthand for a range of processes

Process
<b>Licensing (precondition):</b> Licensure State authorization to practice or provide services.
<b>1. Provider Privileging:</b> Hospital-specific authorization for particular procedures; competency review.
<b>2. Medicaid Provider Enrollment:</b> Screening + ID number to participate in Medicaid (for Medicare—CMS)
<b>3. Private Payer Credentialing:</b> Verifying education, training, sanctions, history.
+ Step: Private Sector Contracting: Negotiating network participation and payment terms.
+ Step: “Loading” Entering an approved provider into the payment system

## International approaches

- Other countries generally face less credentialing duplication because they have fewer payers and relatively centralized registration.
- In most systems, a clinician is verified once, and insurers do not have the incentive, or even the ability to deny or delay participation in insurer networks. Uniform payment rates also facilitate insurers having broad networks.
- The transferable lesson is that centralization of verification and common standards is a characteristic of lower-burden systems.

## Current policies in New Mexico

- Medicaid has recently introduced a standardized system for credentialing, CertifyOS
- Positives: New Mexico requires primary credential verification to payers no more frequently than every three years, and allows provisional credentialing for a period of one year; OSI requires reporting on credentialing applications, approvals, rejections, and time-to-decision

Constraints: State jurisdiction is limited. OSI prescribes credentialing-decision timelines and reporting, but self-insured (ERISA) plans and Medicare Advantage plans are not regulated by OSI; some stakeholders may not realize limitations of state jurisdiction.

# Interviewees said Medicaid is the easiest payer to join, and commercial plans are the hardest

Process
Licensure (Precondition)
<b>1. Provider Privileging</b>
<b>2. Medicaid Program Enrollment</b>
<b>3. Private Payer Credentialing / primary-source verification</b>
+ <i>Private sector contracting</i>
+ <i>“Loading” for payment</i>

Source: Author analysis of interviewees

## There is a perception that insurers act to delay provider credentialing

- The law says that a provider “should be added to the group within 30 days if it is a clean packet. [...] That doesn't happen. That does not happen” This is particularly a problem for behavioral health: “I have spent the last two months trying to add one behavioral psychologist to a group ... [credentialing organization] has not done any of what they are supposed to do.” — IPA administrator
- We have this law that says that credentialing has to be done in 30 days, but it's just not enforced... It's a great law, but it's just not done. [...] I was waiting like three months because I wasn't credentialed and I was like, really guys, like in a health professional shortage area this is so dumb.” —Family physician
- Insurers can deny applications based on network adequacy, incomplete applications, or “other reasons;”
- The definition of a “completed application” gives carriers discretion and back-and-forth slows the process.

## States' approaches to credentialing

1. Application processing deadlines for insurers and Medicaid agencies
2. Retroactive / pending-period payment during the credentialing application review process
3. Standardized application forms: requiring a CAQH (now renamed DataSpring) credentialing form or a statewide form [Risk of single proprietary platform: this former nonprofit organization is now a for-profit organization, noted by one interviewee]
4. Medicaid policies:
  1. Centralized or consolidated credentialing
  2. Providers already credentialed by hospitals, FQHCs, or other entities accepted by MCOs
  3. 48-hour provisional enrollment approval for providers in good standing with a valid NPI, employed by a healthcare entity with a >90% approval rate in the prior 5 years (Maine)

# Policy Options

# 1. Medicaid as Standard Setter

**Medicaid Standard – Options 1a:** Extend Medicaid single-platform credentialing using 2026 Turquoise Care CertifyOS system: require all state-regulated insurers and Medicaid Managed Care plans to accept any provider who submits proof of being an approved Medicaid provider with another insurer/State Medicaid program. **Alternative 1b.** A Medicaid-approved provider who submits a request to a private insurer will be “provisionally” credentialed for 6 months.

**Medicaid Standard – Option 2:** Any individual who was a Medicaid-approved provider in another state before moving to New Mexico, will, once licensed to practice in New Mexico, receive “provisional” credentialing for 6-months. If applying to be a Medicaid provider in New Mexico, they will have 3 months to apply for approval with Medicaid.

## 2. Encourage stakeholders to engage in cross-sector collaboration

- **Encourage health sector actors to collaborate to reduce credentialing problems:** Provider organizations (hospital, physicians, nurses and other clinicians) could convene a meeting with payers to discuss collaborative approaches
- **HCA** could explore sharing provider credentialing data with private plans, such that providers contracting with Medicaid do not have to submit data to multiple payers.

### 3. Actions for state agencies

- Prioritize the Interstate Medical Licensure Compact: Complete IMLC rulemaking
- Encourage OSI to review the progress of insurers on credentialing and report to LHHS on performance, as well as information gaps
- Consider reviewing adequacy of OSI budget to ensure it has resources to collect credentialing and PA data, and resources to analyze the data and report findings on its website, within a specific timeframe
- Encourage the Health Care Authority to report to LHHS on the progress of the Medicaid credentialing system implementation and feasibility of using Medicaid provider enrollment as a standard.
- Agencies will need to consider risks of proprietary systems that may also lead to one vendor, if greater standardization is sought.

## Next steps

- Incorporate discussion and feedback from today (feedback contact on next slide); expand discussion of policy recommendations
- Final report: June 30 with policy recommendations
- Post-Report: dissemination of findings: synthesis in national health policy forums and New Mexico media outreach, academic articles that draw attention to the issues in New Mexico and policy solutions

## How to submit feedback after this session

In addition to in-person feedback and questions, please send us your ideas and suggestions, preferably by June 24 2026, if possible: [ml3111@cumc.columbia.edu](mailto:ml3111@cumc.columbia.edu) & [jlc2310@cumc.columbia.edu](mailto:jlc2310@cumc.columbia.edu)