Reducing Administrative Costs in New Mexico's Health Care System

(Interim Report)

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COLUMBIA | MAILMAN SCHOOL OF PUBLIC HEALTH

Overview of Presentation

Prior work and awareness of problems

Study Aims and Preliminary Findings

A. Administrative burdens	B. Prior Authorization (Dr. Chen)	C. Credentialing

Interim Policy Directions

Discussion (30 minutes)

1. Prior Work and Growing Awareness of the Problem in New Mexico

1. Columbia Lehigh 2022
2. NORC 2023
3. University of New Mexico 2025

1. Laugesen-Gusmano OSI Study

- Task: develop all-payer payment system for New Mexico
- While were focused on reimbursement, our research exposed widespread frustration with claw backs, prior authorization, and credentialing

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.

Many recent policy changes have been consistent with our recommendations

Recommendation	Policy Change
Medicare rates for standardization of payments; increase Medicaid payments	Increase in rates for Medicaid to 120% of Medicaid (HB 2, 2023)
Standardization across Medicaid, IBAC, exchange, and health insurers; endorsed New Mexico all-payer database already underway	Growing focus on coordination--Health Care Authority; data sharing (SB 16 2023 and SB 17 2024); All-payer database implemented
Address administrative costs: streamline processes, rules, prior authorization and Medicaid contracting rules.	OSI timelines for insurers updated for credentialing and prior authorization (2023); increased reporting of data collected

2. NORC study mirrored Columbia-Lehigh OSI findings

- NORC's findings similar to Columbia-Lehigh OSI study
  - Complex billing procedures
  - Prior authorization hassles
  - Frequent rule changes across payers
- Solutions
  - Similar recommendation to Columbia-Lehigh– reduce variation in policies and documentation requirements. standardize prior authorization across Medicaid managed care organizations

3. Sanchez & Sonntag (2025) – UNM Center for Social Policy

- Focus groups and interviews with health care workers in New Mexico.
- Consistent findings with other studies but additionally, they identified:
  - Physicians say out of 30 minutes per patient, 10 minutes is spent on billing, leaving 15-20 for patients.
  - Perception that insurance company requirements are busy work taking away time from care.
  - Delays to treatment, especially “highly specialized and costly care.”
  - Inadequate staffing, which should be addressed with workforce support.
- Recommended simplification, standardization.

Implications—and impact on the next steps

A fragmented administrative system drives up costs and undermines care delivery; efficiency and sustainability in New Mexico's health system needs to be improved. *What's next?*

Build off a consensus of findings and growing understanding of the need for solutions

Dig into processes, statutory requirements and payer variation to develop solutions

Moving policy forward through stakeholder consults and actionable policy recommendations.

2. Project Description: Columbia University Study 2025-26

Project Aims and Deliverables

Aim 1: To identify significant administrative burdens in hospitals and independent medical practices in New Mexico

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

Aim 3: To develop **policy recommendations** for New Mexico and identify opportunities for standardization

Deliverables: Interim and Final Reports; stakeholder engagement and policy briefs.

Overview and Timeline

3. Preliminary Findings and Workplan

3 A. Administrative Processes, Billing and Payer Variation

Summary of Administrative Challenges (United States)

- **Growing awareness** of the need for policy changes and expansion of research on the issue is building evidence for change. Research shows:
  - **Income impacts:** Providers lose revenue from administrative processes and they lose the most from Medicaid Managed Care Organizations (18% vs 4.7% for Medicare, 2.4% for commercial insurers) (Gottlieb et al 2023).
  - **Recent data puts impact higher previously estimated**: The time spent on prior authorization alone is equivalent to the time of 100,000 full-time registered nurses per year (Sahni et al 2024)

Workplan

1. Interview protocol developed and waiting for IRB approval
2. Interviews with stakeholders will explore further:
   - Organizational impact of payer variations in rules and payments
   - Payer differences
   - Solutions
3. Policy recommendations (Final Report)

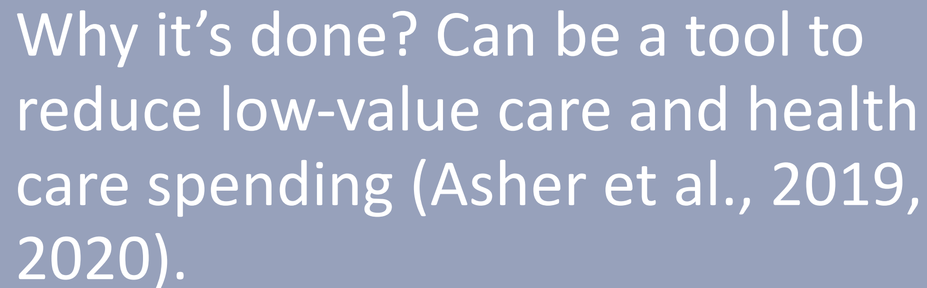
3 B. Prior authorization

Julius L. Chen, PhD

Prior Authorization (PA)

A utilization management process that requires health care providers to obtain approval from a patient's health insurer before they can provide a specific treatment, item, or medication, to ensure that the service is covered.

- Example: Peer-to-peer discussion



Substantial Negative Impacts of Prior Authorization

- PA processes can be administratively burdensome, slow, and uncoordinated
- Payers don't just deny services that are costly or discretionary--even Medicare-covered and compliant services are not automatically covered.
- Reduces timely access to essential services and negatively impacts patient quality of care.
- Creates barriers to providers spending adequate time with their patients, which can drive clinician burnout and fatigue (MACPAC, 2024; AMA, 2024; Pollitz et al., 2023; OIG, 2022).
- May disproportionately negatively impact vulnerable patient populations (OIG, 2023; Smith et al., 2023).
- Possible or hypothesized effect: PA may be contributing to increasing provider consolidation and formation of larger provider groups?

Responsibility for Regulating Prior Authorization

New Mexico—OSI

- The Office of the Superintendent of Insurance (OSI) regulates utilization management practices of health insurers under the Prior Authorization Act of 2019, amended in 2025. Insurers must

  - Accept one form--New Mexico Uniform Prior Authorization Form (or petition OSI to use an alternate form)
  - Comply with clear timelines, expert review of denials
  - Submit data, and annual evaluation of PA practices

- OSI required to review their prior-authorization practices each year to ensure they promote lower cost, better quality, safety, and service.

Federal Regulation of Medicaid in 2026:

- While states may apply for exemptions, there are federal requirements that strengthen protections under Medicaid.

New Mexico Uniform Prior Authorization Form

To file electronically, send to: [INSERT WEB ADDRESS HERE] | **To file via facsimile, send to:** [INSERT FAX NUMBER HERE]

To contact the coverage review team for [INSERT PLAN NAME], please call [INSERT PHONE NUMBER] between the hours of [INSERT HOURS].
For after-hours review, please contact [INSERT PHONE NUMBER].

[1] Priority and Frequency

a. Standard ☐ Services scheduled for this date: | **b. Urgent/Expedited** ☐ Provider certifies that applying the standard review timeline may seriously jeopardize the life or health of the enrollee.

c. Frequency Initial ☐ Extension ☐ Previous Authorization#:

[2] Enrollee Information

a. Enrollee name: | b. Enrollee date of birth: | c. Subscriber/Member ID#:

d. Enrollee street address:

e. City: | f. State: | g. Zip code:

[3] Provider Information: Ordering Provider ☐ Rendering Provider ☐ Both ☐
Please note: processing delays may occur if rendering provider does not have appropriate documentation of medical necessity. Ordering provider may need to initiate prior authorization.

a. Provider name: | b. Provider type/specialty: | c. Administrative contact:

d. NPI #: | e. DEA# if applicable:

f. Clinic/facility name: | g. Clinic/pharmacy/facility street address:

h. City, State, Zip code | i. Phone number and ext.: | j. Facsimile/Email:

[4] Requested medical or behavioral health course of treatment/procedure/device information (skip to Section 8 if drug requested)

a. Service description:

b. Setting/CMS POS Code Outpatient ☐ Inpatient ☐ Home ☐ Office ☐ Other* ☐

c. *Please specify if other:

[5] HCPCS/CPT/CDT/ICD-10 CODES

a. Latest ICD-10 Code	b. HCPCS/CPT/CDT Code	c. Medical Reason

[6] Frequency/Quantity/Repetition Request

a. Does this service involve multiple treatments? Yes ☐ No ☐ If "No," skip to Section 7.

b. Type of service: | c. Name of therapy/agency:

d. Units/Volume/Visits requested: | e. Frequency/length of time needed:

[8] Prescription Drug

a. Diagnosis name and code:

b. Patient Height (if required): | c. Patient Weight (if required):

d. Route of administration Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other* ☐

*Explain if "Other:"

e. Administered: Doctor's office ☐ Dialysis Center ☐ Home Health/Hospice ☐ By patient ☐

Caption: Office of Superintendent of Insurance (OSI) Standard PA Form

Current Policies in Regarding Timeliness of Review

Prior Authorization Type	New Mexico – Maximum Days/Hours
Medical non-urgent	7 days
Medical Urgent/Expedited	24 hours
Prescription Drugs Non-Urgent	3 days
Prescription Drugs Urgent/Expedited	24 hours

Prior authorization are prohibited for some services, under certain conditions

1. Emergency services

2. Contraception services – when there is no cost-sharing, and obstetrical or gynecological ultrasounds

3. Mental health and substance use disorder services, including:
   - Acute or immediately necessary care
   - Acute episodes of chronic mental health or substance use conditions
   - Initial in-network inpatient or outpatient substance use treatment

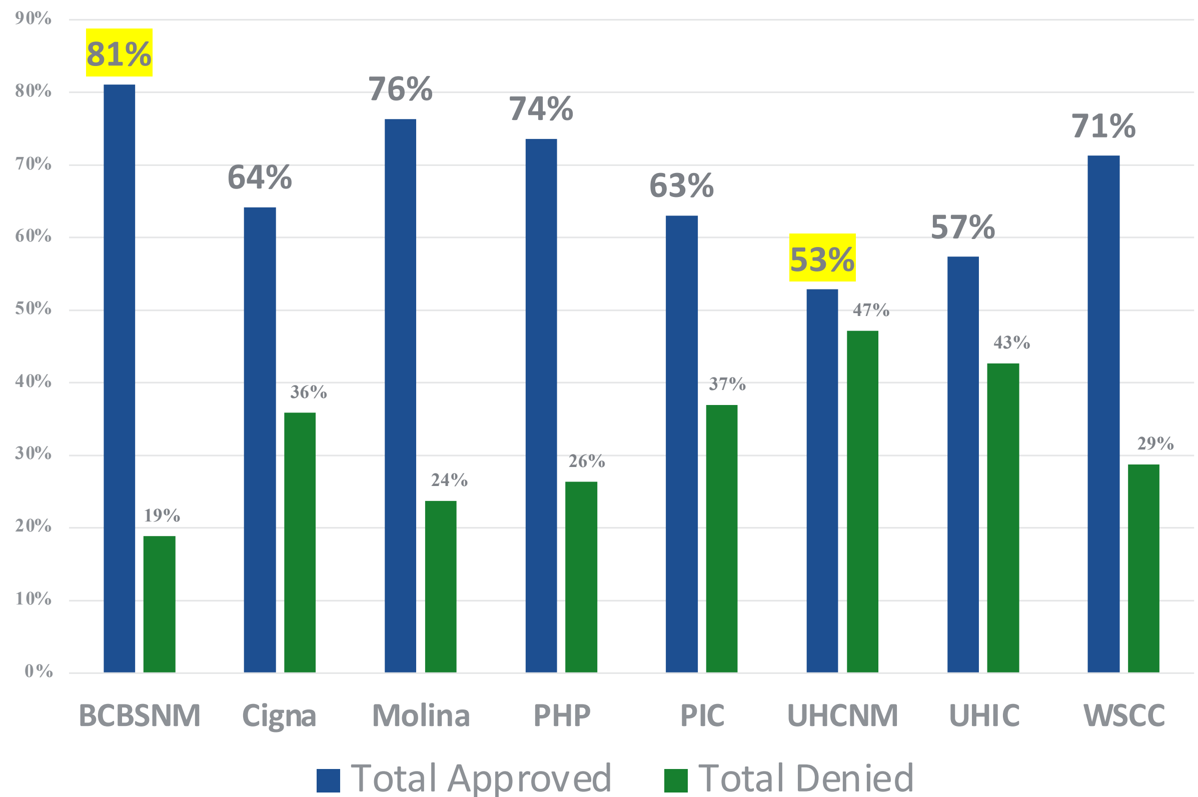
4. Some medications: Approved FDA medically necessary medications for autoimmune disorders, cancer, rare diseases/conditions, or substance use disorders.

Preliminary Analysis: Variability in Prior Authorization Denial Rates, by Payer Type, 2021 (Source: OSI)

Table 1. Plan Year: 2021	**Commercial and Fully-Insured**	**Marketplace**	**IBAC**	**Medicaid (Managed Care)**
Total number of PAs requested	73,511	11,164	29,201	306,295
Total number of PAs denied	16,038	2,980	2,761	67,706
Prior Authorizations denied	**21.82%**	**26.69%**	**9.46%**	**22.10%**
By Service Type				
Prescription drugs denied (%)	44.44%	39.55%	22.72%	**45.42%**
Inpatient physical health services denied (%)	9.59%	**30.06%**	0.88%	5.21%
Outpatient physical health services denied (%)	14.26%	19.44%	10.51%	16.75%
Outpatient mental health and substance use disorder treatment denied (%)	25.78%	**55.56%**	3.76%	25.16%

Recent OSI Data Shows Variation in Approval and Denial Rates by Company (2023)

- Blue Cross Blue Shield New Mexico had the highest overall approval rate (81%)
- United Healthcare of New Mexico had the lowest approval rate (53%)



Review Times for Prior Authorization Requests Also Vary Across Payer Types

Table 2: Processing Time for Prior Authorization Requests, by Payer Type (Plan Year 2021)

	Commercial and Fully-Insured	Marketplace	IBAC	Medicaid Managed Care
Non-urgent/emergent PAs completed within 7 days	83.0%	99.4%	74.1%	90.2%
Urgent/emergent PAs completed within 24 hours	79.3%	95.2%	70.6%	90.9%

3 C. Credentialing

Credentialing

Definition: the process of obtaining and verifying information about a provider and evaluating that provider, when that provider seeks to become a participating provider. Recredentialing renews the credential to assess compliance

Can lead to long delays between physicians accepting a job and starting work and/or billing for services.

Costs: lost revenue: (1) time spent on credentialing (2) staff time (3) if there is a delay in being able to bill.

- Anecdotal evidence suggest some insurers may find ways to extend time to credentialing, by requiring in person office inspections, asking for more documentation

Credentialing Responsibilities

- Medicaid: The Health Care Authority – under federal provider screening and enrollment requirements
- Private insurance: OSI collects data on credentialing

OSI data analysis will inform policy solutions

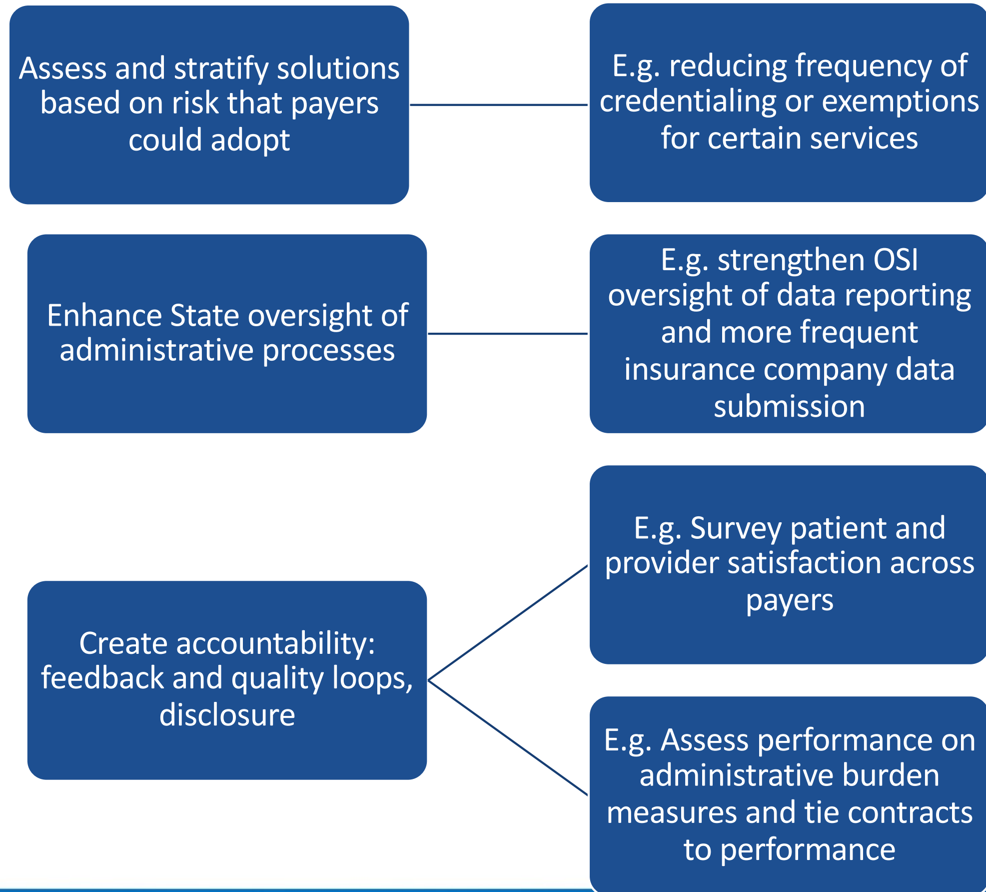
- Initial credentialing and re-credentialing applications received
- Initial credentialing and re-credentialing applications by outcome (denied/approved/rejected/activated)
- Insurer processing times (45 days; 46-90 days; > 90 days)
- Average turnaround time for credentialing and recredentialing (by outcome: denied/approved/rejected/activated)
- Providers terminated by payers for quality reasons
- Monthly average number of contracted providers
- Differences across physical and mental health

Workplan

1. Interview protocol and IRB approval
2. Literature review, identification of state data sources
3. Interviews with stakeholders to understand ongoing challenges
4. Updated data from OSI and data analysis
5. Interviews to test potential policy solutions
6. Development of policy recommendations

Conclusion: Overarching Goal and Preliminary Policy Directions

Streamlined and transparent administrative environment needed to ensure patients receive timely care across New Mexico.



Thank you for listening today.

Please reach out if you have information or suggestions:

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Discussion and questions