An Analysis of Methods to Reduce Administrative Costs in the Health Care System in New Mexico

Final Report to the Legislative Health and Human Services Committee on Analyses Related to Health Care Cost Drivers in New Mexico

12.01.2023

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Agenda

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Background and Methods

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VP Healthcare Programs Research, Project Executive Advisor

Expertise

Value-Based Payment, Care Delivery Reform

Previously Minnesota's State Medicaid Director and CEO of MNsure

Megan Stead

Senior Research Director, Project Director

Expertise

Project Management, Data Management, Analytics and Process Engineering

Current APCD Business Development Lead

Elizabeth McOsker

Research Scientist, Project Manager

Expertise

State Medicaid Programs, Quality Measurement

Previously Research Scientist at Connecticut's Medicaid BH ASO

Beth Landon

Independent Consultant

Expertise

Rural and Frontier Health, Hospital Financing

Previously Director of Policy at New Mexico Hospital Association

Project Scope

Between August 8th and today, "conduct an analysis of methods to reduce administrative costs in the health care system in New Mexico, which shall:

- Identify, describe and analyze methods to reduce the administrative costs in the health care system
- Provide recommendations for health care administrative cost reduction" and subsequently
- "Discuss the possible pros and cons of the methods identified"

Health Care Cost Drivers

Cost Drivers Include:

- Increased use of services, especially as insurance coverage has expanded in the U.S., increasing access to services
- Aging populations with more chronic conditions
- Greater access to advanced therapies and technologies
- Salaries and benefits for healthcare workers
- Prescription drug prices
- Medical device prices
- Hospital consolidation and vertical integration
- Administrative costs

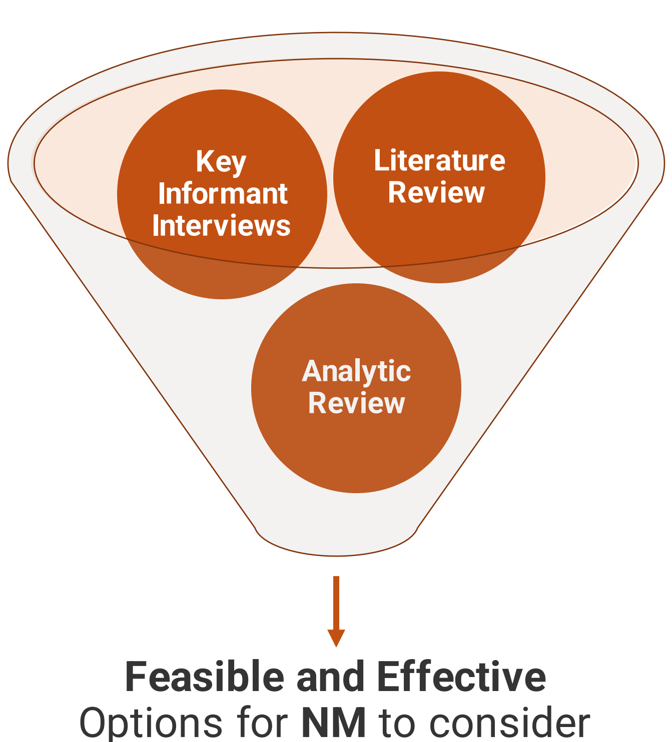
Administrative costs

- "Nonclinical costs of running a medical system"1
- Insurance, claims, prior authorization, eligibility, and billing
- General workplace administration (HR, quality reporting, accreditation)

[1]-David Cutler, "David Cutler on Trimming U.S. Healthcare Costs," 2020, https://www.harvardmagazine.com/2020/04/feature-forum-costliest-health-care.

Project Methods

- 79 articles in initial literature review
- 28 articles in secondary "snowball" review
- 18 key informant interviews, including hospital administrators, state officials, a tribal clinic administrator, advocates, and health plans
- Consultation with Senator Hickey
- Review of NM and US hospital cost report data, rulemaking files, and IRS 990s for non-profit health care organizations



Feasible and Effective
Options for **NM** to consider

Key Findings

Key Findings from Literature Review

Results

- Review included more than 100 articles
- 37 states and more than 15 countries included in results
- 55 articles proposed strategies; 25 articles evaluated strategies
- **Best evidence of cost reduction driven by Health Policy Commissions** (growth caps, price caps, etc.)
- **Standardized billing** and **prior authorization reform** are nearly universal recommendations

Key Findings from Interviews

Findings

Priority recommendations or areas of concern:

- Medical malpractice reform
- Standardize claims and billing
- Prior authorization reform
- Interoperability of technology

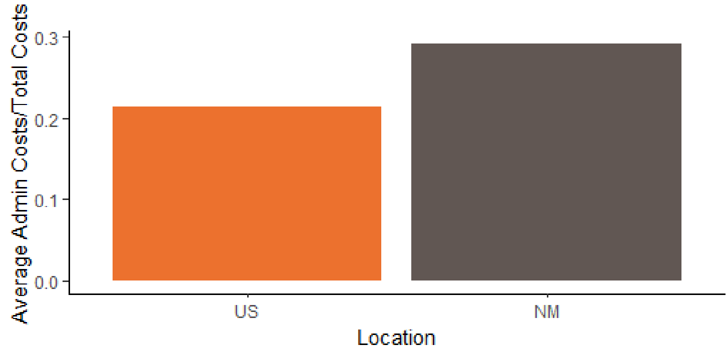
Interviews included

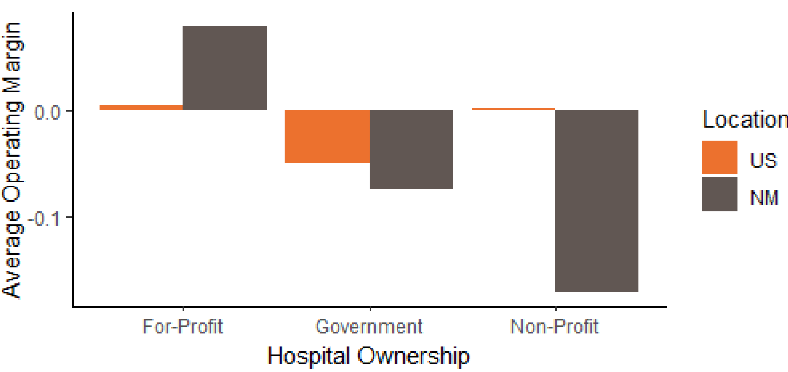
- 5 stakeholders from non-profit healthcare organizations
- 2 stakeholders from for-profit health plans
- 3 stakeholders from the NM legislature
- 3 stakeholders from NM state agencies
- 3 stakeholders from non-profit hospitals
- 2 stakeholders from healthcare technology organizations
- 1 stakeholder from a Tribal 638 clinic

Key Findings from Analytic Review

Findings

- New Mexico hospitals **have significantly higher administrative costs than US average** when standardized to total costs, per bed or per inpatient days. Rurality and ownership do not impact this relationship.
- Government and non-profit New Mexico hospitals **have lower average operating margins than US hospitals**. This accounts for almost 75% of New Mexico's hospitals.





Recommendations

Developing Recommendations

How we developed recommendations

- Sought **areas of agreement** between literature and stakeholders
- Gave precedence to recommendations that **alleviate biggest concerns** of stakeholders
- **Vetted and refined** recommendations with state policy experts at NORC and NM experts on our project team
- Worked to **build off activities**, policies, and legislation NM is already implementing

Overview of Recommendations

Enhance Uniformity and Consistency Across Payers

1. Standardize and reform prior authorization practices
2. Standardize billing forms and claims submission
3. Align state and payer quality metrics with federal ones
4. Standardize organizational contracts

Commission a Special Report on Medical Malpractice

5. Study the impacts of "Med Mal" on hospital budgets and health care workforce
6. Consider interim modifications to HB 75, such as redefining "malpractice claim," "occurrence," and "medical care and related benefits" and prohibiting "venue shopping"

Plan to Implement a Health Strategy and Impact Council

7. Fund and develop a council to provide oversight and monitoring of digital infrastructure and cost containment efforts
8. Monitor trends in spending
9. Consider implementing growth caps
10. Ensure Council has access to state databases (MMIS, HIE, and APCD)
11. Access additional data sources

Recommendation 1

Standardize and Reform Prior Authorization Practices, including:

- Encouraging plans to selectively use prior authorization
- Standardizing the list of services that require prior authorization across payers
- Using a standardized electronic interface for prior authorization

Prior authorizations should only be used “for those services that really need it”

"Creating a standardized list of services that must go through a prior authorization process for all payers would help to reduce the time burden and administrative frustrations”[2]

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

Recommendation 2

Develop and Implement an Administrative Simplification Package to Standardize Billing Forms and Claims Submission Across Payers

Getting a claim paid currently "seems to be unreasonably difficult" because "every insurance has its own set of parameters and rules and criteria"

Standardization of billing implemented in Minnesota is "…reducing the need for phone-based follow-up and questions between providers and payers, helping reduce an estimated $15.5 million - $22 million annual expense statewide for the calls"[3]

[3]- Center for Health Care Purchasing Improvement, "Minnesota's Health Care Administrative Simplification Initiative" (Minnesota Department of Health, n.d.), https://www.health.state.mn.us/facilities/ehealth/asa/docs/factsheetadminsimp.pdf.

Recommendation 3

Align state and payer quality metrics with federal ones, including appropriately limiting use of additional metrics by payers

"Reducing the reporting cadence and the magnitude of the reporting and the list of measures is a huge opportunity"

Physicians rarely treat patients differently based on their insurer, so "it does not make much sense to have a separate quality assessment at the provider level for patients insured by Medicare, Medicaid, and private insurance"[4]

[4]-David Cutler, "David Cutler on Trimming U.S. Healthcare Costs," 2020, https://www.harvardmagazine.com/2020/04/feature-forum-costliest-health-care.

Recommendation 4

Require Appropriate Standardization of Organizational Contracts to advance compliance with policies of interest, including

- administrative simplification,
- standardization and reform of prior authorization
- alignment of quality metrics
- submission of data to the state APCD and HIE

There could be "a huge outcry" from health plans

Standardized provider contracts "increase the effectiveness of automated fraud detection and could reduce compliance costs by limiting the number of providers subject to the highest level of scrutiny"[5]

[5]-David Scheinker et al., "Reducing Administrative Costs in US Health Care: Assessing Single Payer and Its Alternatives," Health Services Research 56, no. 4 (2021): 615–25, https://doi.org/10.1111/1475-6773.13649.

Recommendation 5

Conduct an unbiased and comprehensive further study of the impacts of the state's medical malpractice requirements on hospital budgets and the health care workforce

Malpractice insurance is an "**untenable expense for a lot of our providers,** particularly our small rural providers, or people that do not have a well-established practice. I guess that is one of the reasons why we **are not getting new providers come into the state** and why we are **losing people who have trained here**"

Recommendation 6

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

- Synonymously define:
  - "Malpractice claim" and "occurrence" so that a single injury event is recognized and treated as a single claim or occurrence;
  - "Medical care and related benefits" to be only costs paid by or on behalf of the injured patient and not tied to billed charges.
- Prohibit "venue shopping" and obligate a case to be heard in the county where the health care provider is located, or where the patient resides, unless there are well-defined and limited criteria for a change in venue.

"We're losing physicians.
We may lose some hospitals."

Recommendation 7

Fund and develop a Health Strategy and Impact Council to provide oversight and monitoring of New Mexico's digital infrastructure and cost containment efforts.

- House the Health Strategy and Impact Council within the Health Care Authority
- Develop and fund the entity based on best practices in considering governance and staffing, policy scope and accountability measures, data access, funding and resources, and stakeholder engagement

Council would need to be staffed with health care "expertise" and "access to data"

Health Policy Commissions develop the capacity of the state to "collect, assess the quality of, and analyze the health care spending data they receive to inform the state's specific data use goals" and "measure, set, and enforce growth targets designed to lower costs and improve value across the health care system"[6]

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

Recommendation 8

Through the Health Strategy and Impact Council, monitor trends in healthcare spending, including reviewing federal funding opportunities and evaluating proposed changes in ownership or affiliation

People in NM are "extraordinarily worried" about the "toxic environment" that comes with mergers and acquisitions and private equity takeovers

"In Massachusetts, providers and provider organizations must notify the Health Policy Commission and state attorney general of any material change in ownership or affiliation, defined broadly to include mergers, acquisitions, affiliations, joint ventures, partnerships, and other arrangements. If the proposed material changes are considered likely to affect the state's ability to meet cost growth benchmarks, the commission can conduct a detailed impact review of the proposed change."[7]

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

Recommendation 9

Through the Health Strategy and Impact Council, consider implementing growth caps to mitigate healthcare cost drivers, including appropriate enforcement mechanisms

"A growth cap can be a good way, if you've got the right infrastructure and technical ability to monitor it and keep everybody accountable to it"

Over 8 years since Massachusetts created a growth cap benchmark (of 3.1% growth), average annual health care spending growth has been 2.84%.[8] Nationally, health care spending growth was around 4.4% over the same time period.[9]

8-Massachusetts Health Policy Commission, "2022 Health Care Cost Trends Report and Policy Recommendations," 2022, https://www.mass.gov/doc/2022-health-care-cost-trends-report-and-policy-recommendations/download.
9-Imani Telesford et al., "How Has U.S. Spending on Healthcare Changed over Time?," Peterson-KFF Health System Tracker, 2023, https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/.

Recommendation 10

Ensure that the Health Strategy and Impact Council has access to state administered databases (i.e., MMIS-R, HIE, and APCD) for policy monitoring, evaluation, and recommendations

- Continue developing an All-Payer Claims Database in alignment with other digital infrastructure and house under the new Health Care Authority
- Continue implementing New Mexico’s HIE (SYNCRONYS) in alignment with other digital infrastructure and using single sign-on integration for providers

Data is currently "fragmented” or “unavailable”

One of the key recommendations of RAND's Hospital Price Transparency Study is to “support the development and maintenance of APCDs and allow these APCDs to be used for price reporting purposes”[10]

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

Recommendation 11

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

There are "huge opportunities in administrative analytics" if the state chooses to invest in data

CMS recently required employer sponsored insurance (ESI) and marketplace health plans to post agreed rates with network providers, by service, as part of a payment transparency rule[11]

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

Closing

Project Summary

- Over the past 3.5 months the NORC team:
- Conducted a literature review and analytic review of hospital cost reports and other sources
- Interviewed or consulted with 20 key informants
- Developed recommendations for short- and long-term admin cost reduction
  - Develop legislative packages to enhance uniformity and consistency across payers
  - Commission a special report or legislative committee to recommend Medical Malpractice reforms
  - Develop a strategic plan for implementing a Health Strategy and Impact Council
- Wrote a final report and appendices that includes detailed findings and recommendations, including strategies we did not recommend, additional information on methods, interviews, and the analytic review
- Next steps—actually implementing changes—is the hard part!

Questions?

Thank you.

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