NEW MEXICO HEALTHCARE EXPENDITURES DATA NEEDS

Prepared for the New Mexico Legislative Council Service

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Executive Summary

The Legislative Health and Human Services Committee (LHHSC) is concerned about rising hospital expenses and investigating ways to better leverage data to drive policy decisions. The drivers of rising costs are complex. These costs can include medical equipment, pharmaceuticals, staffing, patient access, and health insurance (commercial and public payers). There is a need to understand all healthcare expenditures and to have a system that collects and compiles New Mexico-specific expenditure data. In addition, New Mexico has a unique population and landscape. The question of tracking healthcare accessibility, quality, and equity needs to be addressed.

UNM Bureau of Business and Economic Research (BBER) and Arrowhead Center at New Mexico State University have prepared this report detailing a review of best practices and strategies for the implementation and maintenance of state healthcare expenditure databases for New Mexico and 14 other states. The review of best practices and strategies for the implementation and maintenance of state healthcare expenditure databases includes examples from states with active state healthcare expenditure databases such as Massachusetts, Rhode Island, and Connecticut. Additionally, this review includes an investigation of the benefits, advantages, use cases, and policy implications of the implementation, and maintenance of a state healthcare expenditure database.

New Mexico does compare well to other states with healthcare expenditure databases with the public release of the New Mexico All Payers Claims Database (NM APCD) this past fall. APCDs are the most difficult and expensive part of setting up a healthcare expenditure database. This database currently has data back to 2020. The NM APCD collects information on paid claims for New Mexico residents from commercial (or private) health insurance plans and the state's Medicaid program. Staff at the Department of Health (DOH) estimate that the initial data might cover about 75% of the market. Health care plans with less than 500 individuals are not required to submit data as well as ones offering only specific disease; accident or injury; hospital or other fixed indemnity; disability; long-term care; and vision coverage. Also not in this dataset are employer-sponsored plans regulated under the federal Employee Retirement Income Security Act (ERISA) of 1974, and governmental or tribal programs or facilities that provide health care services to American Indians and Alaska Natives may submit data voluntarily. Data for federal health insurance programs including Federal Employee Health Benefits (FEHB), Indian Health Service (IHS), Veterans Health Administration, and TRICARE is not currently submitted or available to state APCDs. These exclusions are typical in other states. The NM APCD does not have data for the denied claims or claims for uninsured or people who self-pay for services. This data set only captures claims data and does not include non-claims data.

As stated above the NM APCD does not collect non-claims cost data. Non-claims data needs to also be captured to accurately calculate total healthcare expenditure in New Mexico. Non-claims data can include prescription drug spending (less rebates), net costs of private health insurance, and provider payments. Good sources for these items might include pharmacy benefit managers (PBMs), manufacturer reports for rebates and discounts, and national datasets like those from IQVIA[1], which provides detailed insights into retail and

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[1] The Use of Medicines in the U.S. 2024: Usage and Spending Trends and Outlook to 2028, May 07,2024
https://www.iqvia.com/insights/the-iqvia-institute/reports-and-publications/reports/the-use-of-medicines-in-the-us-2024

non-retail drug spending trends. Net costs of private health insurance are the difference between premiums earned and benefits incurred for insurance providers. This information can be gathered from state insurance regulatory filings and reports submitted to the National Association of Insurance Commissioners (NAIC) and available in the InsData database[2]. In some cases, it may be possible to derive the net costs of private health insurance from U.S. Securities and Exchange Commission (SEC) filings for publicly traded insurance companies, like Molina Healthcare[3], however, if the company operates in multiple states, state-specific data may not be available directly. Similarly, Form 990s for nonprofit insurance companies, like Presbyterian Healthcare[4], may potentially be used to calculate the net costs of private health insurance.

Finally, there are non-medical drivers of health costs such as transportation if more than 50 miles or 45 minutes is required, to capture rural area access issues. Or maybe items around demographics, low income, educational attainment, housing, employment opportunities, or environmental factors.

In this report, we propose that Arrowhead Center at NMSU in conjunction with BBER would be a good fit for collecting and curating the non-claims and non-medical drivers of health costs and in creating reports around total healthcare expenditures in New Mexico for the legislature and public interests.

During our review of the literature and data availability, the following New Mexico data items stood out:

- In 2023, New Mexico private employment data shows the Health Care & Social Assistance industry sector with average annual employment of 123,876 accounts for about 18 percent of all private employment. The Health Care and Social Assistance industry sector is the largest private employment sector in New Mexico and policies need to consider the impact on this industry sector.

- The Health Care and Social Assistance industry sector has 10,651 establishments paying an average weekly wage of $985 with a total of $6,347,496,004 wages in 2023 (See Appendix table New Mexico 2023 Annual Private Industry Employment). Note on the annual average weekly wage in New Mexico, that the $985 seen for 2023 when compared to all states is one of the lowest. Of the surrounding states, the annual average weekly wage for 2023, in no particular order, is Arizona ($1,262), Utah ($1,071), Colorado ($1,249), Oklahoma ($1,097), and Texas ($1,146). Industry wages are one of the cost factors for healthcare.

- Centers for Medicare & Medicaid Services (CMS) annually publishes a data series that measures annual health spending in the U.S. by type of good or service delivered, source of funding for those services and sponsor. Data on projected spending are also available. The CMS personal health care spending data for New Mexico show that since 1980, personal health care expenditures have grown from $927 million to over $17 billion in 2020, with an annual growth rate of 7.6%, as shown in Figure 1 on the next page.

- In New Mexico, in 2023 the American Community Survey 1-year Estimates for the civilian noninstitutionalized population show that 90.9 percent have healthcare insurance. The 9.1 percent without insurance represent approximately 188,600 individuals in New Mexico. Note that Native

[2]NAIC © 1991-2025 National Association of Insurance Commissioners, https://content.naic.org/industry/insdata
[3]EDGAR: Company Search Results, Jan 28, 2025, https://www.sec.gov/edgar/browse/?CIK=1179929&owner=exclude
[4] ProPublica Nonprofit Explorer search results, Jan 28, 2025, https://projects.propublica.org/nonprofits/organizations/850105601

American Indians who have no other health insurance than Indian Health Services are coded as uninsured in this survey. Based on the same survey Native Americans are 9.3% of the New Mexico population[5]. Regardless, health insurance costs are another cost factor.

Figure 1. Personal Health Care Expenditures by Provider, New Mexico 1980-2020[6]

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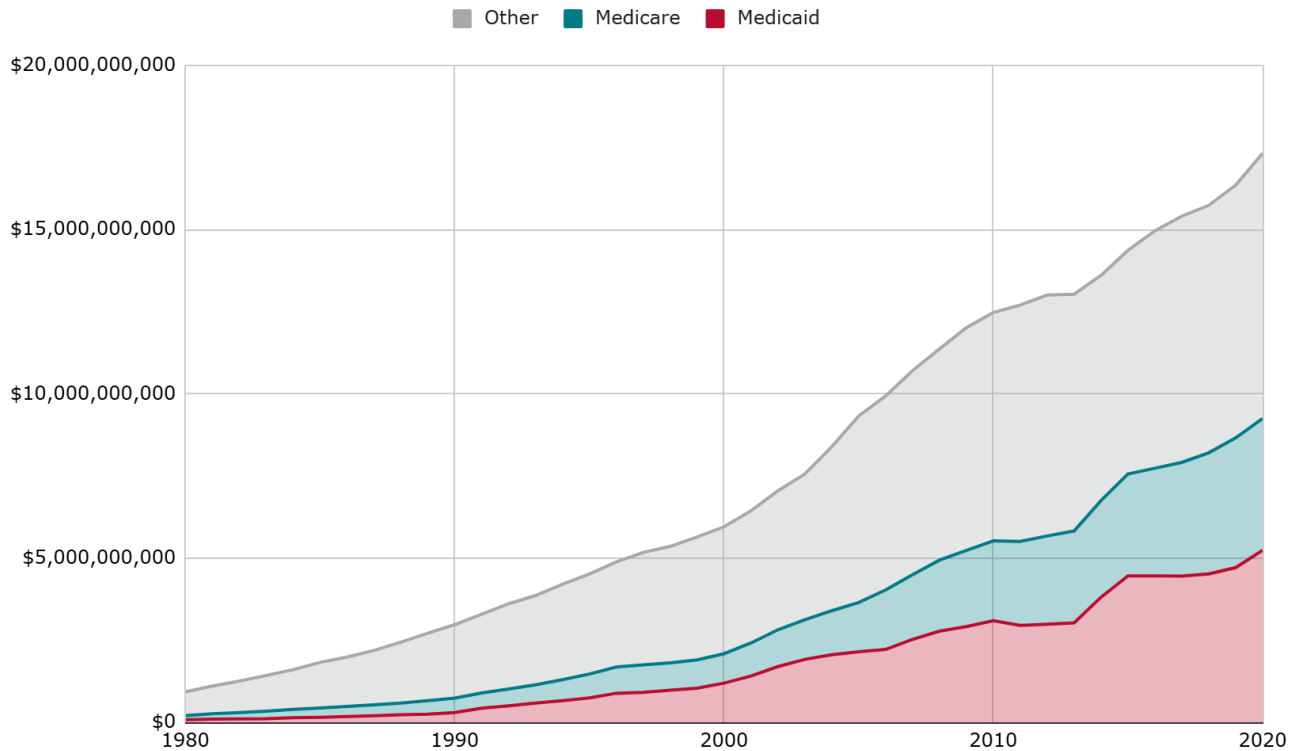
[5] Based on U.S. Census Bureau, U.S. Department of Commerce. "Race." American Community Survey, ACS 1-Year Estimates Detailed Tables, Table B02001, 2023, https://data.census.gov/table/ACSDT1Y2023.B02001?t=Race and Ethnicity&g=040XX00US35. Accessed on January 28, 2025.

[6] Centers for Medicare & Medicaid Services, Jan 28, 2025, https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/state-provider

Introduction

The rising hospital and health-related expenses in New Mexico may be impacting individuals and families, especially those with low income in both financial situations and health outcomes. A survey of more than 1,400 New Mexican adults, conducted from June 6 to July 8, 2024, found that three in four (75%) experienced at least one healthcare affordability burden in the past year[7]. For this and other healthcare concerns, the Legislative Health and Human Services Committee (LHHSC) wants to investigate ways to better leverage data to drive policy decisions. The drivers of rising costs are complex. These costs can include medical equipment, pharmaceuticals, staffing, patient access, and health insurance (commercial and public payers). There are a variety of ways other states have approached collecting data on these costs. This report will compare 14 states and New Mexico to identify healthcare data systems, specifically healthcare expenditure databases. It will also look at what data sets could be included in a healthcare expenditure database and the costs that the other states have experienced setting up their healthcare data systems.

Many healthcare expenditure databases collect claim and non-claim payments, including prescription drug spending (less rebates) and net costs of private health insurance. The net costs of private health insurance are the difference between premiums earned and benefits incurred for insurance providers. The payments of all claim and non-claim payments are often referred to as total medical expenses, and this is collected from private payers and public programs. This includes Medicare, Medicaid, commercial carriers, hospitals, clinics, and self-insured employers. When this information is not collected, it is impossible to know what is driving the costs and if policy changes impact the costs in the desired manner.

The typical use case for a healthcare expenditure database is to provide data for the development of a healthcare cost growth benchmark. These databases have been used to establish benchmarks in several other states. A healthcare expenditure database can be used to develop global budgets and is most useful in identifying cost drivers of increasing health expenditures since the data can be segmented by specific health insurance markets (Medicare, Medicaid, and commercial), by individual payers by market, and by advanced network (hospitals, primary care practices, and specialists). By understanding the primary cost drivers, other initiatives can be implemented to address those issues specifically, such as monitoring the costs of specific high-cost prescription drugs.

New Mexico has a diverse population with a unique blend of cultures across a large state that has both urban and rural communities. As we dive into an economic look at healthcare in New Mexico, we need to keep in perspective that this can also affect healthcare costs. For rural communities, there are issues of healthcare access as many may need to travel more than 45 minutes to see a doctor or medical provider. For our Native American Indians, Hispanic populations, and other minority communities there may be issues of healthcare equity and quality. These are not new issues, but part of the background of healthcare services in New Mexico. A healthcare expenditure database needs to collect data not only on the healthcare business of claims cost but also on individual and community outcomes to truly measure and understand the healthcare needs of our state.

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[7] Altarum's Consumer Healthcare Experience State Survey (CHESS) https://healthcarevaluehub.org/advocate-resources/publications/new-mexico-survey-respondents-struggle-afford-high-health-care-costs-worry-about-affording-health-care-future-support-government

Healthcare Expenditure Database Overview

A healthcare expenditure database that meets the goal of identifying healthcare services and goods cost drivers in New Mexico, may indeed be data from a variety of disparate sources. In the very definition of a "database," an extensive healthcare expenditure database is many smaller data sets that are linked together.[8] The database can then produce reports that tell a more comprehensive story on healthcare in New Mexico. Health expenditures can be presented for benchmarking at the state level, by specific health insurance markets (Medicare, Medicaid, and commercial), by individual payers by market, and by advanced networks (hospitals, primary care practices, and specialists).

Ideally, a healthcare expenditure database should collect as much information on individual spending around healthcare services and goods. The data should include the obvious direct costs of medical visits for doctors, dentists, or other professionals. Costs like hospital stays and emergency room visits. There are additional costs related to healthcare treatment that include medicine purchases (over-the-counter and prescription) and medical equipment (such things as oxygen concentrators, wheelchairs, etc.). The payment of healthcare insurance premiums & deductibles. The cost of transportation to access healthcare services both emergency and in rural communities distance to healthcare facilities. The collection of these healthcare costs is available from a variety of sources that include hospitals; doctors' offices; insurance companies; Medicaid; Medicare; tax data on healthcare services and goods; and consumer spending.

Because the purpose of a healthcare expenditure database is to analyze the drivers of rising costs, it also needs to collect information on the costs that the producers of healthcare services and goods experience. For example, hospitals and doctors' offices pay wages to employees that must be covered by what they charge. Not only does the database need to collect the cost to those who need healthcare services but the very costs that the healthcare providers experience in producing these goods and services.

Healthcare access, utilization, and quality data should also be a part of a healthcare expenditure database. In recent years, many states have recognized that hospitals, doctor's offices, and insurance providers are all businesses driven in part by the need to show sound financial statements. This provides incentives for how they bill, pay, and deny claims.[9] It also encourages medical professionals regarding what treatment plans they typically recommend for individuals. At the same time, New Mexicans need affordable, accessible, quality healthcare that meets our diverse population's needs. The database then also needs to collect healthcare outcomes alongside demographic data. Additionally, it would help if the data collected on individuals could be tracked across all the other datasets in a de-identified manner in accordance with state and federal privacy policies. This linking at the individual level would provide for the most accurate costs to outcome comparisons. This linking could also provide a rich source of data for a variety of researchers that would benefit healthcare services.

Healthcare expenditure databases differ from All Payer Claims Databases (APCD) in that it is aggregated and includes more than an APCD. An All Payer Claims Database is used for detailed analyses of specific services,

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[8] See Oracle's extensive database definition https://www.oracle.com/database/what-is-database/
[9] Coustasse A, Layton W, Nelson L, Walker V. UPCODING MEDICARE: IS HEALTHCARE FRAUD AND ABUSE INCREASING? Perspect Health Inf Manag. 2021 Oct 1;18(4):1f. PMID: 34975355; PMCID: PMC8649706.

procedures, and diagnoses across providers, which is possible because of the individual-level claims data. All Payer Claims Databases seem to be implemented first in the states we have studied. A healthcare expenditure database builds on and supplements an APCD.

Many healthcare expenditure databases collect claim and non-claim payments for healthcare services and goods, including prescription drug spending (less rebates) and net costs of private health insurance. The net cost of private health insurance is the difference between premiums earned and benefits incurred for insurance providers. The payments of all claim and non-claim payments are often referred to as total medical expenses, and this is collected from private payers and public programs, including Medicare, Medicaid, commercial carriers, and self-insured employers. To measure health expenditure levels, these aggregate figures are divided by the population reported by payers and public programs.

Finally, a healthcare expenditure database can be used by the same entities that supply data to research specific topics of use to them. Such as healthcare providers might not always be able to follow long-term outcomes of cancer treatments or insurance providers might be able to show that claim denials are not egregious as reported. Hospitals could use the data to justify their budgets. There can be value given back to the individual reporters to improve their services and business.

Rationale for Healthcare Expenditure Database in New Mexico

A recent Commonwealth Fund study identified an alarming trend occurring in New Mexico regarding premiums and deductibles. According to the study, since 2010, premiums and deductibles in New Mexico have risen from 10-11.9% of median income (which at the time was higher than all but 40 states) to now New Mexico being one of only five states with healthcare premiums and deductibles greater than 15% of median income. This type of cost increase is exactly why New Mexico could benefit from a healthcare expenditure database. Reports and studies using the database would allow healthcare experts, lawmakers, policymakers, and stakeholders access to New Mexico-specific data continuously. Yearly data will help identify emerging trends and specific cost drivers allowing quicker policy responses.

A typical use case for a healthcare expenditure database is to provide data for the development of a healthcare cost growth benchmark. These databases have been used to establish benchmarks in several other states. Healthcare expenditure databases can be used to develop global budgets and also can be useful in identifying cost drivers of increasing health expenditures since the data can be segmented by specific health insurance markets (Medicare, Medicaid, and commercial), by individual payers by market, and by advanced networks (hospitals, primary care practices, and specialists). By understanding the primary cost drivers, other initiatives can be implemented to address those issues specifically, such as monitoring the costs of specific high-cost prescription drugs. Connecticut does this with 10 specific high-cost drugs determined by the Office of Health Strategy (OHS) as: (1) A substantial cost to the state, or (2) Critical to public health.

The reason for implementing cost growth benchmarks is usually to attempt to manage healthcare costs that are growing at a rate faster than incomes. If healthcare costs are growing faster than incomes, healthcare expenditures will consume a larger and larger portion of citizen income, which reduces the standard of living and increases the financial burden. Benchmarks are typically developed to track income growth to limit healthcare expenditures from consuming an increasing portion of citizen income.

New Mexico recently released initial access to the New Mexico All Payers Claims Database (NM APCD) publicly. APCDs are the most difficult and expensive part of setting up a healthcare expenditure database. This database has been under development for many years and is now reaching a level of robustness that can provide the typical benefits of an APCD. The NM APCD collects information on paid claims for New Mexico residents from commercial (or private) health insurance plans and the state's Medicaid program. Staff at the Department of Health (DOH) estimate that the initial data might cover about 75% of the market. This represents an extremely important step for the creation of a healthcare expenditure database. The NM APCD can be combined with the remaining non-claim data in order to establish a healthcare expenditure database.

New Mexico Healthcare Industry Economic Data

As we look into healthcare expenditures, it is important to understand the economic activity of the healthcare industry in New Mexico. In 2023, New Mexico private employment data shows the Health Care & Social Assistance industry sector with average annual employment of 123,876 accounts for about 18 percent of all private employment. The Health Care and Social Assistance industry sector is the largest private employment sector in New Mexico in 2023.

Figure 2. Average Annual Private Employment Industry Sectors, 2023
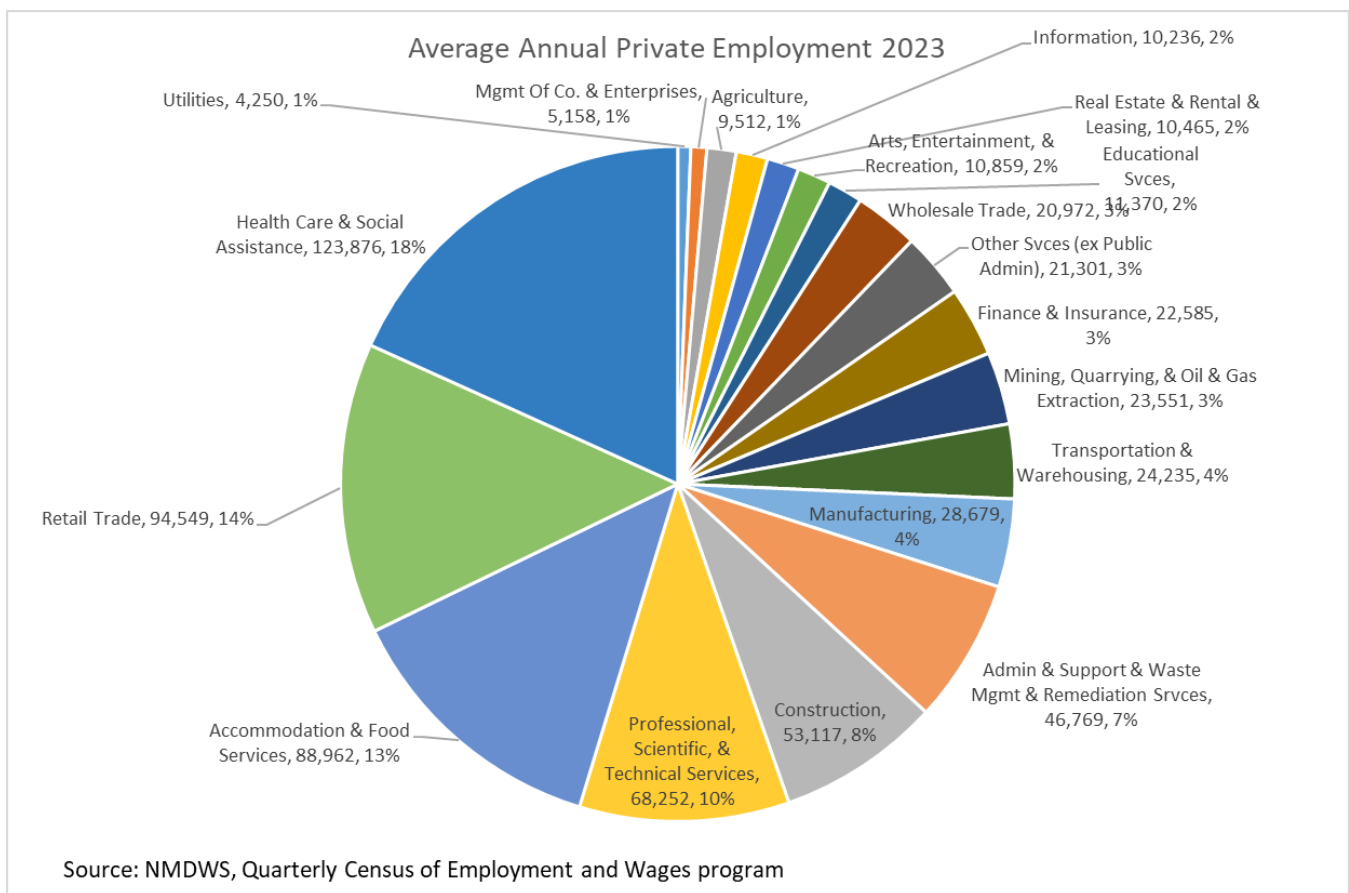
Source: NMDWS, Quarterly Census of Employment and Wages program

The Health Care and Social Assistance industry sector has 10,651 establishments paying an average weekly wage of $985 with a total of $6,347,496,004 wages in 2023 (See Appendix table New Mexico 2023 Annual Private Industry Employment). Because wages are a part of healthcare cost drivers, it's important to look at how they have changed over time. In the first quarter of 2014, average weekly wages were $759 for the Health Care and Social Assistance sector. Average weekly wages in the Health Care and Social Assistance sector had risen to $827 by the first quarter of 2019 and during COVID-19-impacted years up to $949 by the first quarter of

2022 (See figure 3[10]). Using the Bureau of Labor Statistics Consumer Price Index (CPI) Inflation Calculator, the $759 in 2014 should have risen to $970.73 in 2023. From this inflation calculation, the $985 for 2023 seen in New Mexico is a little higher than the CPI would expect. This simple calculation does not take into account issues of understaffing and the difficulties some occupations are seeing in recruiting qualified staff within the healthcare sector in New Mexico. Staffing shortages in technical occupations do cause upward forces on wages. Policies that might have a future impact on wage growth that have been implemented in recent years include support for more individuals to receive training in high-demand medical jobs[11]. Just a final note on the annual average weekly wage in New Mexico, the $985 seen for 2023 when compared to all states is one of the lowest. Of the surrounding states, the annual average weekly wage for 2023, in no particular order, is Arizona ($1,262), Utah ($1,071), Colorado ($1,249), Oklahoma ($1,097), and Texas ($1,146).

Figure 3. NM Average Weekly Wage for Health Care and Social Assistance Industry Sector

Private ownership Quarterly Census of Employment and Wages data for Health Care and Social Assistance in New Mexico
Average Weekly Wage

Source: NMDWS, Quarterly Census of Employment and Wages program
Downloaded: 01/13/2025 12:12 PM

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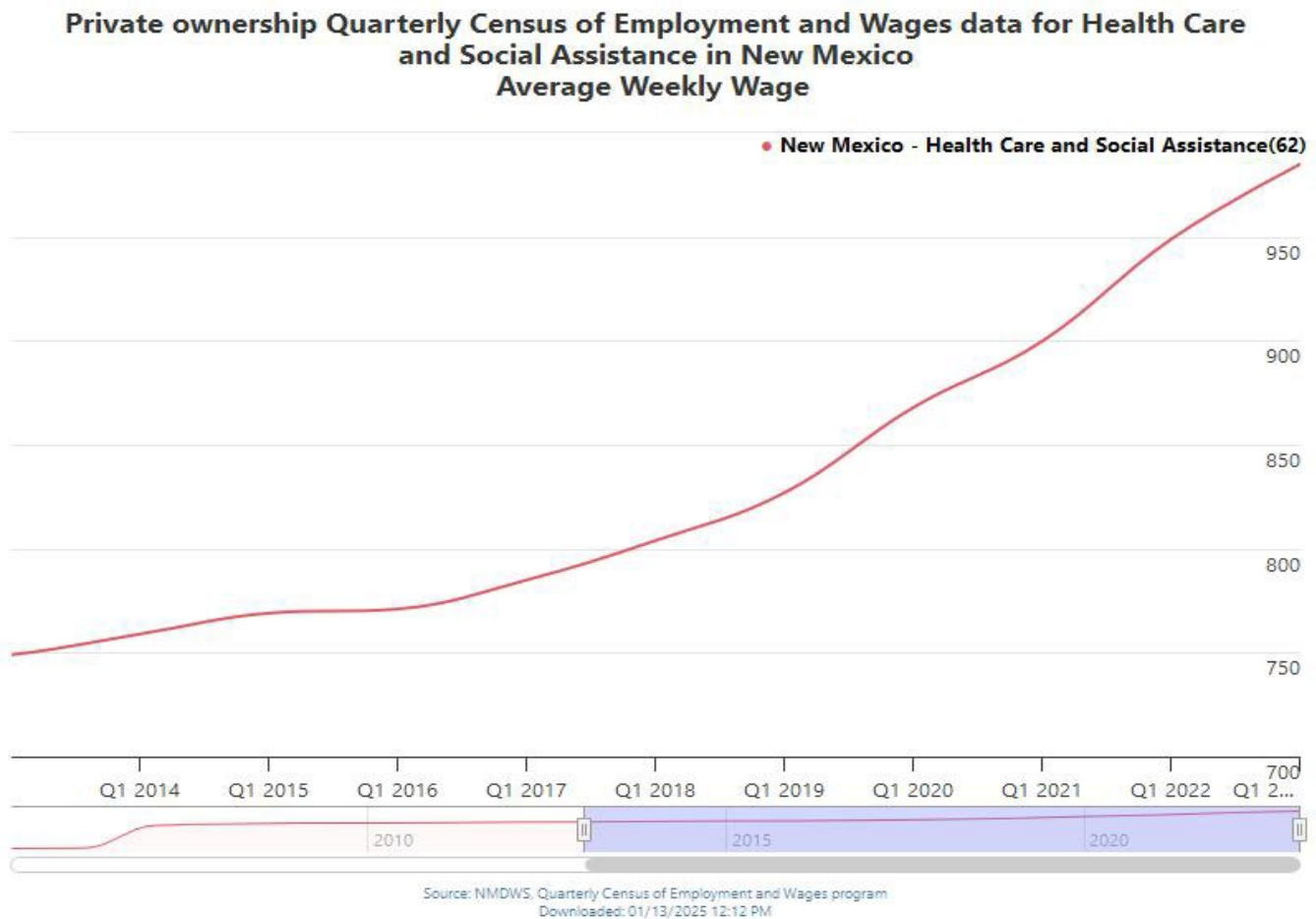
[10] Average Weekly Wage chart downloaded from NM Workforce Connection website, laser.state.nm.us select QCEW data and set filter to Total All and Annual data. Then set the chart to Average Weekly Wage.
[11] UNM Hospital news release on 2024 legislative funding including programs like money for College of Nursing and Project ECHO
https://hsc.unm.edu/news/2024/06/hsc-newsroom-post-lgx-funding.html

Statewide, the percentage of the Health Care and Social Assistance industry sector to all industries is 18 percent. When looking at county data, we see that this distribution is not even across the state (See Figure 4). The counties with the highest percentage of Health Care and Social Assistance, at more than 30 percent, are Cibola, Mora, San Miguel, and Socorro counties. The counties with the lowest percentage of Health Care and Social Assistance, with less than 10 percent, are Colfax, Eddy, Lea, and Los Alamos counties. Note that data from Catron and Harding counties are suppressed due to confidentiality. Attempts of policy to impact employment and wages in this industry may have an uneven effect across the state.

Figure 4. Healthcare and Social Assistance Employment Percentage by New Mexico County, 2023

Health Care and Social Assistance Percent Employment By County In 2023

County	Percent
Bernalillo	18.4%
Catron*	0.0%
Chaves	20.7%
Cibola	33.1%
Colfax	8.2%
Curry	23.5%
De Baca	15.7%
Doña Ana	27.3%
Eddy	9.4%
Grant	15.3%
Guadalupe	20.8%
Harding *	0.0%
Hidalgo	17.2%
Lea	9.1%
Lincoln	10.7%
Los Alamos	4.7%
Luna	20.8%
McKinley	24.9%
Mora	37.9%
Otero	26.0%
Quay	19.4%
Rio Arriba	24.7%
Roosevelt	12.4%
San Juan	19.5%
San Miguel	37.9%
Sandoval	17.3%
Santa Fe	17.2%
Sierra	27.8%
Socorro	35.7%
Taos	19.3%
Torrance	13.8%
Union	21.0%
Valencia	21.5%

* Data are suppressed

Source: NMDWS, Quarterly Census of Employment and Wages program.

State Comparisons

The following information is a selection of states which have databases that measure healthcare expenditures. We specifically looked for when the state first set up legislation, the driving reason, what database projects are maintained, budgets, and any additional summary information to consider.

Colorado

The Center for Improving Value in Health Care (CIVHC), an independent non-profit that maintains the Colorado All Payer Claims Database (CO APCD), was established in 2009. It was appointed as the administrator of the CO APCD in 2010 by the Colorado Department of Health Care Policy and Financing[12]. The legislation for this unique setup detailed the reporting needs, "[to] facilitate the reporting of health care and health quality data that results in transparent and public reporting of safety, quality, cost, and efficiency information; and analysis of health care spending and utilization patterns for purposes that improve the population's health, improve the care experience, and control costs." (C.R.S. 25.5-1.204(1))

CO APCD includes data from Commercial Payers, Medicaid & Medicare (FFS and Advantage). This system does not include federal programs such as Veterans Affairs (VA), Tricare, Indian Health Services, uninsured and self-pay claims, nor a majority of ERISA-based self-insured employers.

The CO APCD costs approximately $5 million per year to operate and provide for ongoing enhancements. The planning process was supported through a generous grant from The Colorado Trust, and both The Colorado Trust and the Colorado Health Foundation provide support for the years of implementation and development necessary to reach self-sustainability.[13]

The Colorado Department of Public Health & Environment maintains a Center for Health and Environmental Data that maintains the Colorado Health Information Dataset (COHID); Survey Research; and Registries and Vital Statistics. These datasets assist in providing data for evaluating health trends in Colorado and are part of the Colorado Department of Public Health & Environment budget.

The cost of the Colorado Health Care expenditure system is the CO APCD budget of approximately $5 million per year plus the Colorado Department of Public Health & Environment budget to maintain their databases.

The Colorado Health Care expenditure data system is a mixture of the CO APCD and the Colorado Department of Public Health & Environment. The strength of the Colorado setup for the CO APCD is that the non-profit can quickly adapt to new data needs and data collection requirements while still being directed by state statutes and the Colorado Department of Health Care Policy and Financing. It also appears that the cost is considerably less than what is seen in other states where the APCD database is located within the government. The CO APCD notes that it was set up with the intent to link with other datasets to provide better research. The difficulty they have run into includes protecting confidential data of individuals and access to clinical data.

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[12]Center for Improving Value in Health Care (CIVHC), Jan 28, 2025, https://civhc.org/about-civhc/who-we-are/
[13] Center for Improving Value in Health Care (CIVHC), Jan 28, 2025, https://civhc.org/knowledgebase/how-is-the-co-apcd-paid-for-and-how-much-does-it-cost/

Primarily this has resulted in the slow release of research publications. Second, not all data systems capture all the data that the CO APCD wants to collect resulting in data gaps or the inability to link or aggregate data.

Connecticut

In 2017, Connecticut established the Office of Health Strategy (OHS) through a bipartisan effort of the Connecticut General Assembly.[14] This office centralized many existing state resources into one unit with the goal of improving health, reducing consumer costs, and supporting modernization through the use of technology. The primary databases maintained by OHS include:

- All-Payers Claims Database[15] created in 2012, is Connecticut's hub for insurance claims. The records include medical claims, pharmacy claims, patient eligibility, and provider information. Data reporting is required for all insurers covering more than 3,000 people. Database fields are detailed in the APCD Data Dictionary helping reporters know what data to collect and submit[16].
- Healthcare Benchmark Initiative[17] has the goals of helping all residents access affordable, high-quality healthcare, enhancing spending on primary care, allowing for creative solutions to address healthcare needs, and lowering healthcare spending growth. The initiatives main efforts are: (1) setting annual healthcare cost growth targets for 2021-2025, (2) increasing primary care spending as a percentage of total healthcare expenditure, with a goal of 10% by 2025, (3) providing healthcare quality benchmarks for all public and private payers, (4) reporting healthcare spending growth, and (5) monitoring care organizations and different payment models.
- Patient Discharge Data[18] gathered from providers in four main categories: (1) Inpatient discharges from acute care hospitals, (2) Outpatient surgery discharges from hospitals, (3) Outpatient surgery discharges from ambulatory surgery centers (ASC), and (4) Emergency room discharges.
- Prescription Drug Cost Transparency[19] requires drug manufacturers, pharmacy benefit managers, health plans, and others to report information that explains high price increases and high-priced new drugs. The laws focus on a list of 10 outpatient prescription drugs determined by the Office of Health Strategy (OHS) as: (1) A substantial cost to the state, or (2) critical to public health.
- Connecticut AHEAD[20] is a program led by the U.S. Centers for Medicare and Medicaid Services (CMS) to develop a state total cost of care model, the State Advancing All-Payer Health Equity Approaches and Development Model (AHEAD Model). The components of the total cost of care models include:
  - Hospital Global Budgets: a voluntary program for hospitals to establish global budgets for stable, predictable sources of revenue for a hospital based on prior expenditures.

14 Connecticut Office of Health Strategy, https://portal.ct.gov/das/-/media/das/communications/communications-list-docs/digest/digest-2020-2021/office-of-health-strategy.pdf

15 https://portal.ct.gov/ohs/programs-and-initiatives/all-payer-claims-database

16 https://portal.ct.gov/ohs/-/media/ohs-beta/pdf/all-payer-claims-database/ct-apcd-data-dictionary.pdf?rev=f834d00ca4da4ba786985bc5ecf601fa

17 https://portal.ct.gov/ohs/programs-and-initiatives/healthcare-benchmark-initiative?language=en_US

18 https://portal.ct.gov/ohs/programs-and-initiatives/patient-discharge-data?language=en_US

19 https://portal.ct.gov/ohs/programs-and-initiatives/prescription-drug-cost-transparency?language=en_US

20 https://portal.ct.gov/ohs/programs-and-initiatives/connecticut-ahead?language=en_US

- o Primary Care AHEAD: voluntary program for primary care providers that offers prospective, flexible, and enhanced payments to increase capacity to deliver advanced primary care services.
    - o Health Equity Plan: to help prioritize community-driven strategies for improving population health and reducing identified disparities in access to health care services and in health outcomes.
- Hospital Data Reporting[21]: Hospitals are required to submit financial documents, including Audited Financial Statements, Medicare Cost Reports, and Officers and Directors. This data is then available for the public to review all in one place. Eliminating the need to research each hospital's website for this information.
- Race, Ethnicity, Language, and Disability (REL-D) Data Collection[22]: Self-reported data for each patient and client to identify disparities in health.
- Hospital Community Benefit[23]: Reporting system for documenting voluntary services and activities that hospitals provide to promote the health and well-being of the communities they serve.

The annual operating budget for OHS was $6,177,697 in FY 2021 with $2,149,240 from the general fund and $4,028,457 from the insurance fund.[24]

The strength of the Connecticut healthcare expenditure data system is that it is all under one agency that can focus on healthcare issues. Their data system is comprehensive representing not just individual costs but also hospital costs. The data system is funded by the state from the general fund and from their insurance fund.

Maine

The Maine Health Data Organization (MHDO) was set up in 1996[25]. MHDO maintains CompareMaine, a web portal (www.comparemaine.org) with payment and quality of patient care. MHDO's governing statute is Title 22, Chapter 1683. The initial legislation was done in 1995 and its purpose was "that uniform systems of reporting health care information be established; that all providers and payers who are required to file reports do so in a manner consistent with these systems; and that, using the least restrictive means practicable for the protection of privileged health care information, public access to those reports be ensured[26]".

CompareMaine collects and maintains data from the All Payer Claims Database (APCD) which was set up in 2003 from health insurance claims. The APCD currently holds claims from commercial insurance carriers, third-party administrators (TPAs), pharmacy benefit managers (PBMs), dental benefit administrators, MaineCare (Maine Medicaid), and CMS (Medicare).

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[21] https://portal.ct.gov/ohs/programs-and-initiatives/hospital-data-reporting?language=en_US
[22] https://portal.ct.gov/ohs/programs-and-initiatives/race-ethnicity-language-and-disability-data-collection?language=en_US
[23] https://portal.ct.gov/ohs/programs-and-initiatives/hospital-community-benefit?language=en_US
[24] https://portal.ct.gov/das/-/media/das/communications/communications-list-docs/digest/digest-2020-2021/office-of-health-strategy.pdf
[25] The Source on Healthcare Price and Competion: a project of UC College of the Law San Francisco, January 28, 2025, https://sourceonhealthcare.org/states/maine/
[26] https://www.mainelegislature.org/legis/statutes/22/title22ch1683.pdf

Additionally, MHDO publishes four reports annually on prescription costs: "International Referenced Rate Pricing for Prescription Drugs", "Prescription Drug Pricing Transparency", "Rx Costs", and "Maine Hospitals Participating in Federal 340B Drug Program."

MHDO is part of the Maine government and had $1,741,510 in expenditures for fiscal year 2023[27].

The strength of the Maine Health Data Organization was its implementation in the mid 1990s allowing for a long-term set of data. Additionally, all health data are organized under a single entity with a Data Release Subcommittee that evaluates research requests and manages confidentiality issues.

Maryland

The Maryland Health Care Commission (MHCC) manages the Medical Care Data Base (MCDB) which is Maryland's All Payer Claims Database (APCD). The MHCC was created in 1999 by the Maryland General Assembly with the intent "establish a streamlined health care regulatory system in this state in a manner such that a single state health policy can be better articulated, coordinated, and implemented[28]". The MHCC is organized into four centers: 1) The Center for Health Care Facilities Planning and Development, 2) The Center for Health Information Technology and Innovative Care Delivery, 3) The Center for Analysis and Information Systems, and 4) The Center for Quality Measurement and Reporting. The four centers cover collecting data, analyzing data and website presentation of data as well as regulatory oversight in certain cases. What stands out in this setup is the advocacy of the Center for Quality Measurement and Reporting to advocate for electronic healthcare transactions and data interchange between payers and providers.

The Center for Health Care Facilities Planning and Development compiles annual data sets on the service capacity and development of general and special hospitals, freestanding ambulatory surgical facilities, nursing homes, home health agencies, hospices, assisted living facilities, and adult day care facilities. The Center also obtains hospital registry databases on cardiac surgery, cardiac catheterization, and percutaneous coronary intervention for use in regulatory oversight of these services.

The Center for Health Information and Innovate Care Delivery is responsible for the Commission's health information technology and advanced primary care initiatives. Certify electronic health networks that accept electronic health care transactions originating in Maryland. Develop programs to promote electronic data interchange between payers and providers. Designate management service organizations to promote the adoption and advanced use of electronic health records. Electronic health information exchange promises to bring vital clinical information to the point of care, helping to improve the safety and quality of health care while decreasing overall healthcare costs. Health information technology requires two crucial components to be effective – widespread use of electronic health records and electronic health information exchange.

The Center for Analysis and Information Systems is part of the information-sharing of cybersecurity threat intelligence (CTI) for the State of Maryland's agencies and organizations. The MD-ISAC promotes an environment in which members can collaborate on cybersecurity events or incidents specific to the State of

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[27] Main State Government Annual Report 2022-2023 page 325, https://www.maine.gov/budget/sites/maine.gov.budget/files/inline-files/2022-2023%20Maine%20State%20Government%20Annual%20Report.pdf
[28] https://mhcc.maryland.gov/mhcc/pages/home/mhcc_overview/mhcc_overview.aspx

Maryland networks & systems and provides a safe environment in which healthcare providers can safely share information without concern that the information will cause unwanted attention to their organization.

The Center for Quality Measurement and Reporting is responsible for the creation, development, and maintenance of the Maryland Health Care Quality Reports website. This site is a comprehensive, consumer-friendly tool to help assist consumers in making informed healthcare decisions and to promote greater transparency and accountability among healthcare providers. The consumer website publicly reports on performance measures for hospitals, long-term care facilities, health insurance plans, and an outpatient guide is currently under development.

- The Hospital Guide displays information on hospital performance for quality measures, consumer ratings, infection data, and hospital prices by payer type for medical conditions and procedures.
- The Maryland Medical Care Data Base (MCDB) is Maryland's All Payer Claims Database (APCD).
- Physician Profiles show county-level data related to the numbers and types of physicians and county demographics.
- The Center publishes the Long Term Care Guide which provides a tool to compare nursing homes, assisted living facilities, hospices, home health agencies, and adult day care facilities in Maryland. Consumers can use the guide to locate services and planning tools.
- The Center publishes the Nursing Home Family Experience of Care survey. In this survey, the loved ones of nursing home residents are asked about their experiences and satisfaction with Maryland nursing homes.
- The Center publishes the Health Plan Guide in order to provide consumers with information regarding commercial health plans available in Maryland. The guide offers information on what services are provided, how effective the plans are in providing services, and member ratings of experiences and satisfaction.

The MHCC FY2022 Budget Appropriation was $39,502,668[29].

The strength of the MHCC is the organization into four centers with two of the centers focused on the electronic side of data sharing and security of data sharing. This focus makes it easier for the healthcare industry to meet reporting requirements potentially cutting reporting costs.

Massachusetts

As a result of state legislation in 2012, Massachusetts became the first state to establish a statewide benchmark for healthcare cost growth.[30] This legislation also established the Center for Health Information and Analysis (CHIA), "an independent agency … primary hub for health care data and a primary source of health care analytics that support policy development."[31] The goal of state legislation was to improve healthcare quality and contain costs, through transparency, efficiency, and innovation.

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[29] 2022 AnnualReport Maryland Health Care Commission page 18, https://mhcc.maryland.gov/mhcc/pages/plr/plr/documents/2022/MHCC_Annual_Rpt_FY_2022.pdf

[30] https://www.milbank.org/publications/the-massachusetts-health-care-cost-growth-benchmark-and-accountability-mechanisms-stakeholder-perspectives/

[31] https://www.chiamass.gov/about-chia/about-the-agency/mission-and-history

CHIA collects data in five main categories:

- MA APCD[32]: an all-payer claims database from public and private payers providing insurance in Massachusetts. The data covers a number of services, including medical, pharmacy, dental, vision, behavioral health, and specialty services. MA APCD allows for analysis and reporting on population health management, quality outcomes, costs, and pricing variations.
- Massachusetts Acute Hospital Case Mix Database[33]: a database comprising the following databases: Hospital Inpatient Discharge Database (HIDD), Emergency Department Database (EDD), and Outpatient Observation Database (OOD). These databases include detailed information on inpatient discharges, emergency department visits and observation stays. For each of these patient encounter types, detailed patient information is provided including patient demographics, admission and discharge information, diagnostic and procedural coding, provider details, and detailed charge information.
- Hospitals and Other Health Providers: Large detailed datasets from hospitals and other health care providers are collected and maintained to offer a variety of analytic products with the goal of supporting information transparency, cost containment, and quality improvement in the health care system. Some data is available publicly, such as Hospital and Long Term Care Facility cost reports, and other datasets can be requested. These requestable datasets include: Adult Day Health Cost Reports, Adult Foster Care Cost Reports, Ambulance and Chair Car Services Cost Reports, Group Adult Foster Care Cost Reports, Community Health Center Cost Reports, Hospital Charge Book Data, Hospital Financial Performance Data, Hospital and Other Provider Financial Statements, Nursing Services Cost Reports.
- Payments and Expenditures Data: Healthcare cost and payment information from healthcare payers and providers is collected directly from all health payers in Massachusetts to compile the following datasets: Total Medical Expenses, Total Health Care Expenditures, Alternative Payment Methods, Provider Payment Methods, Relative Price, and Network Average Relative Price Dollar Amount. These datasets are used to conduct a variety of studies, including:
  - analyses of total medical expenses;
  - variation in price levels among providers for health care services;
  - payment methods and levels among providers; and
  - health care market concentration.
- Insurance and Coverage Data: To monitor changes in cost and benefit levels of health insurance, enrollment and premium data, and spending of premium dollars by payers for their members over time are collected.

The enacted budget FY2023 for CHIA was $32,400,000[34].

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[32] https://www.chiamass.gov/chia-data/ma-apcd
[33] https://www.chiamass.gov/chia-data/case-mix-data
[34] https://budget.digital.mass.gov/summary/fy23/enacted/independents/center-for-health-info-and-analysis/

Massachusetts's strength is it has a robust program of healthcare data collection that provides significant detail for specific research applications, as well as broader figures that can be used for policymaking, and specifically benchmarking for healthcare cost growth.

Minnesota

The Minnesota Department of Health, in addition to health statistics in general, maintains healthcare cost and quality statistics. They have a robust set of data programs and include a Health Economics Program[35] that provides not only research papers around healthcare cost, quality, and access but specifically provides applied policy analysis to monitor changes in the healthcare marketplace. Below is a list of the many data programs that Minnesota has.

- 340B Drug Pricing Program: Beginning in 2024, Minnesota healthcare entities that participate as "covered entities" in the federal 340B Drug Pricing Program are required to annually report data related to their 340B prescription drug purchases and payments to the Minnesota Department of Health (MDH). MDH submits its findings in annual reports to the Legislature on the reported data.[36]
- Adverse Health Events: events that hospitals and licensed ambulatory surgical centers are required to report to the Minnesota Department of Health.
- All Payer Claims Database (APCD): in 2008 legislation was passed to set up the APCD with the purpose of creating greater transparency of provider cost and quality. Authorized uses for NM APCD include:
    - Evaluating the performance of the Health Care Homes program;
    - Studying hospital readmission rates and trends, in collaboration with the Reducing Avoidable Readmissions Effectively (RARE) campaign;
    - Analyzing variations in healthcare costs, quality, utilization, and illness burden based on geographical areas or populations;
    - Evaluating the State Innovation Model (SIM) testing grant received by the Departments of Health and Human Services;
    - Conducting a one-time study of chronic pain management procedures (completed in January 2015);
    - Assessing the feasibility of conducting state-based risk adjustment in the individual and small group health insurance markets; and
    - Studying trends in health care spending for specific chronic conditions and risk factors.
- MN has a Public Health Data Access Portal: Similar data to other states with births, deaths, and illnesses.
- Behavioral Risk Factor Surveillance Survey (BRFSS): specific areas of health interest covering a long list of items including Antibiotics, Asthma, Cardiovascular Heath, Diabetes, immunization, Medical Cannabis, Oral Health, Opioids, Refugee Health, STDs, and more.
- Minnesota Health Access Survey: A biannual survey that studies how Minnesotans access health insurance and health care services.

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[35] https://www.health.state.mn.us/data/economics/index.html
[36] https://www.health.state.mn.us/data/340b/index.html

- Minnesota Injury Data Access System (MIDAS): A data portal that can filter information related to injury, violence, and substance use for Minnesotans.
- Minnesota Public Health Data Access: Environmental public health data can be used to inform policies, change behavior, and help communities uncover issues to develop solutions and protections for the hazards, exposures, and socioeconomic factors that influence our health. These include such items as cold weather, drinking water quality, air quality, pesticide poisoning, etc.
- Minnesota Student Survey: This survey is administered every three years to students in regular public elementary and secondary schools, charter schools, and tribal schools in fifth, eighth, ninth, and 11th grades. It includes questions about a wide variety of youth behaviors, including risk behaviors such as alcohol, tobacco and other drug use, violence and sexual activity, as well as positive behaviors and connection to family, school and community.

The Minnesota Department of Health budget for the 2024-2025 state biennial period, which is July 1, 2023, to June 30, 2025, is projected at $1.53 billion[37].

The strength of the Minnesota data system is that they have a program dedicated to health economics that monitors and reports on the healthcare marketplace and specifically provides reports for policymakers.

New Hampshire

In 2003, New Hampshire passed legislation to set up a comprehensive healthcare information system (Chapter 420-G:11-a)[38]. The setup put together a system that is managed by both the Department of Justice (Insurance Department) and the Department of Health and Human Services.

The New Hampshire Comprehensive Health Care Information System (CHIS)[39] was created by state statute to make health care data "available as a resource for insurers, employers, providers, purchasers of healthcare, and state agencies to continuously review health care utilization, expenditures, and performance in New Hampshire and to enhance the ability of New Hampshire consumers and employers to make informed and cost-effective health care choices." The statute also required that the New Hampshire Insurance Department (NHID) and the NH Department of Health and Human Services (NH DHHS) partner on the project and both contribute to the funding. The same legislation that created the CHIS also enacted statutes that mandated that health insurance carriers submit their encrypted health care claims data and Health Employer Data and Information Set (HEDIS) data to the state[40].

The New Hampshire Insurance Department (NHID) maintains NH HealthCost, a website that provides estimates of healthcare costs from the claims data New Hampshire Comprehensive Health Information System (NHCHIS). Quality measures available on this site are the results from patient surveys that were collected from the National Hospital Consumer Assessment of Healthcare Providers and Systems.

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[37] https://www.health.state.mn.us/about/budget.html
[38] https://www.gencourt.state.nh.us/rsa/html/XXXVII/420-G/420-G-11-a.htm
[39] https://nhchis.com/
[40] https://www.gencourt.state.nh.us/rsa/html/XXXVII/420-G/420-G-11.htm

NH DHHS provides access to a number of health datasets including a Data Portal similar to other state health and human service departments for community health topics.

Because two different departments work on Healthcare data it's difficult to determine an overall cost. However, the survey response from the NHCHIS personnel noted that initial development for their ACPD was a couple of million and that the vendor Milliman Corporation who collects the claims database records charges a quarterly fee for the quarterly extract of about $110,000 (split between two agencies) an extract and a monthly $15,200 (split between two agencies) for monthly claims data collection.

The strength of the New Hampshire health care data system is that the cost is split between two different state government agencies. The funding from the insurance department comes from fees assessed to insurance companies.

New Jersey

The New Jersey Department of Health has the Hospital Financial Reports Unit responsible for overseeing various quarterly and annual hospital data submissions and reports, including but not limited to the annual Acute Care Hospital (ACH) Cost Reports, quarterly unaudited financial statements, quarterly ACH Utilization Reports (known as B-2s), quarterly Apollo reports, monthly Early Warning System (EWS) reports, and annual Admissions and Revenue (ARR) report. These data sets have been collected since the 1980s. New Jersey does not currently have an active APCD but is considering legislation and is in the process of planning an APCD. New Jersey Department of Health does have the Center for Health Statistics & Informatics (CHS) which covers data on births, deaths, chronic illnesses, injuries, and behavioral risk factors, among other types of information which is similar to New Mexico's. In New Jersey, the Department of Health is separate from the Department of Human Services which runs the state's Medicaid program and serves individuals with disabilities among other programs. Data sets between the two programs are reported individually.

The New Jersey Department of Health appropriations for fiscal 2022 was adjusted to $1.187 billion. [41]

The strength of the New Jersey data system is that hospital finances have been collected since the 1980s and provide good statistics to evaluate their services. While New Jersey has robust data collection by a variety of state agencies and individual reports are well presented, the reports don't seem as organized or accessible as some of the other states reviewed.

New Mexico

The New Mexico Health Care Authority manages a wide list of programs. They provide many of the same health statistics seen in other states; an extensive list is available at https://www.nmhealth.org/about/erd/bvrhs/hsp/. Additional healthcare-related data is available from New Mexico's Indicator Based Information System (NM-IBIS). In the fall of 2024, the New Mexico All Payers Claims Database (NM APCD) was published at https://apcd.doh.nm.gov/ by the New Mexico Department of Health.

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[41]The State of New Jersey Governor's Budget Message Detaled Budget Recommendations Fiscal Year 2023, March 2022 page 244, https://www.nj.gov/treasury/omb/publications/23budget/FY2023BudgetDetail-FullPDF.pdf

This first step is important for the healthcare expenditure database but what it does not have nor does the rest of the datasets currently available are the non-claims costs.

The current requested budget for the NM APCD is $670,000[42]. The document notes that the APCD is matching funds as it meets the Health Information System [HIS] Act requirements. These funds fall under the Community and Health Systems Epidemiology Bureau (CHSEB) for Federal funding ($2,193,765.54).

The strength of the New Mexico system is that the Department of Health and New Mexico Health Care Authority work together with the myriad of datasets that are being managed between them. Both agencies, among others of the NM state government, have had difficulties with staffing in recent years. What is currently not being collected are non-claims costs and should be collected for total health care expenditures calculations are non-claims data.

Oregon

Within the Oregon Health Authority, the Office of Health Analytics (ORS 442.011 to 442.025 initially set up in 1977[43]) manages many programs and collections from more than a dozen data sources. Their goal is to provide information to better understand and improve upon the quality and equity of Oregon's healthcare system and outcomes.

- All Payer All Claims (APAC) was established in 2009 and described in statute (ORS 442.373). APAC receives medical claims, dental claims, pharmacy claims, payment amounts, member demographics, billed premiums, and provider information. Data are received from insurance companies, third-party administrators, and pharmacy benefits managers identified as mandatory reporters. Data not captured are ERISA Self-Insured Coverage, commercial health plans with fewer than 5,000, Tricare, Federal Employees Health Benefits Programs, VA, Indian Health Services, and Uninsured. APAC data collection is done through contracts with Milliman, Inc.
- Behavioral Health Analytics provides Medicaid and behavioral health program data.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey asks consumers and patients to report on and evaluate their experiences with health care. OHA administers approximately 45,000 CAHPS health plan (Medicaid) surveys annually among its adult and child members.
- Hospital Reporting Program collects, maintains, analyzes, and reports information about hospitals in Oregon hospital financial and utilization data to inform policy-making. Data sets include Audited Financials, Utilization, Hospital and ED Discharge, and data from APAC.
- Medicaid Data for Administrative Records.
- MHSIP Surveys are validated surveys to measure Medicaid clients' perceptions of the quality and efficiency of the mental health services they receive. The program consists of four surveys, which vary based on the client's age and the type of services they received. These surveys are: 1) adults who have

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42 NM Health FY-26 Appropriation Request, https://realfile60151d4795ce4d11abc799080b50384f.s3.amazonaws.com/356b1392-eb89-4aea-bdd6-b4b6a202bb47?AWSAccessKeyId=AKIAJBKPT2UF7EZ6B7YA&Expires=1738086434&Signature=INQoWtYUFxo%2FpSFKIzH67BS7X14%3D&response-content-disposition=inline%3B%20filename%3D"Department%20of%20Health.pdf"&response-content-type=application%2F.pdf
43 https://www.oregon.gov/oha/HPA/Pages/Statutes-Details.aspx?View={BF005535-B542-446F-B0B7-61328A304AEA}&SelectedID=10

received outpatient services; 2) adults who have received residential treatment services; 3) parents or guardians of youth 0-17 years of age who have received mental health services; and 4) youth 14-17 years of age who have received mental health services. The four surveys assess the perception of mental health services across several domains, such as access to services, quality of services, satisfaction with surveys, and treatment outcomes and participation.

- Oregon Health Insurance Survey is a statewide run survey asking residents questions about how well the health care system is (or isn't) working for people – from how many people have health insurance, to how much they pay in medical bills, to their ability to get care when they need it.

- Quality Metrics - The Oregon Health Authority uses quality health metrics to understand how well Coordinated Care Organizations (CCOs) are serving Oregon Health Plan members. Quality measures assess healthcare processes, outcomes, patient experiences, and more. An important part of Oregon's measurement strategy is the CCO Quality Incentive Program, which gives CCOs the opportunity to earn bonus money. To earn this bonus money, CCOs must show improvement on a set of quality "incentive measures." The incentive measures are selected each year by a public body called the Metrics and Scoring Committee. The committee also selects benchmarks that determine how much CCOs must improve to earn the bonus money[44].

- Sustainable Health Care Cost Growth Target - The Oregon Legislature through Senate Bill 889 (2019 Laws) and House Bill 2081 (2021 Laws) has established the Sustainable Health Care Cost Growth Target Program within the Oregon Health Authority (OHA). The cost of health care in Oregon has grown and is projected to grow faster than both the state economy and Oregonians' wages. The healthcare cost growth target is a target for the annual per capita rate of growth of total healthcare spending in the state. Cost increases of health insurance companies and healthcare provider organizations will be compared to the growth target each year. The program will also evaluate and annually report on cost increases and drivers of healthcare costs[45].

The OHA budget for the 2023-25 biennium will be $35.8 billion[46].

The strength of the Oregon healthcare data system is the long history of collecting and reporting data. They also have a variety of data collection programs and reports aimed at quality of care. Oregon uses data in recent years to evaluate the cost increase of health care and compare it to income growth with the aim of keeping the system affordable.

Rhode Island

The Rhode Island Department of Health maintains a variety of health statistics and the HealthFacts RI Database[47]. HealthFacts RI[48] is Rhode Island's All-Payer Claims Database, collecting healthcare claims data from Medicare, Medicaid, and major commercial payers. Enabled by 2008 legislation, it aims to improve healthcare system understanding and performance. HealthFacts RI includes claims data from payers with over

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[44] https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/quality-metrics.aspx , accessed January 28, 2025.

[45] https://www.oregon.gov/oha/HPA/HP/Pages/Sustainable-Health-Care-Cost-Growth-Target.aspx , accessed January 28, 2025.

[46] Oregon Halth Authority 2023-25 Legislatively Adopted Budget, https://www.oregon.gov/oha/Budget/2023-25%20Legislatively%20Adopted%20Budget.pdf

[47] https://healthsourceri.com/ accessed January 28, 2025.

[48] https://health.ri.gov/data/healthfactsri/ accessed January 28, 2025.

3,000 Rhode Island-covered lives. Data collection started in 2014, with payers submitting medical, dental, pharmacy, provider, alternative payment, and supplemental files. The data is anonymous and Rhode Island residents can opt out.

HealthFacts RI collects data in the following categories[49]:

- Eligibility: member-specific medical, dental, and pharmacy enrollment information, plus member demographic information and information regarding an individual's plan and coverage type.
- Medical Claims: medical services information for covered individuals during the reporting period, includes cost and utilization data, such as diagnosis and procedure codes, charge amount, paid amount, copay amount, deductible amount, type of setting, and rendering/billing provider information.
- Dental Claims: dental services information for covered individuals, including procedure code, charge amount, paid amount, copay amount, deductible amount, rendering/billing provider information, dental quadrant, and tooth surface codes.
- Pharmacy Claims: pharmacy services information for covered individuals during the reporting period, including National Drug Code, national pharmacy ID, prescribing provider information, generic/brand drug indicator, plan paid amount, copay amount, and deductible amount.
- Provider: provider information associated with medical, dental, and pharmacy services, including data related to healthcare providers themselves, including elements such as National Provider Identifier, provider name, provider specialty, and provider geographic information (e.g., city, ZIP code, etc.)
- Alternative Payment Model (APM): Includes non-fee-for-service (non-claims) payments, supplementing claims payment data to provide a full picture of healthcare payments. Types, amounts, and covered services under APMs vary across contracts and payers, such as care management fees, incentive payments, infrastructure and operations payments, shared savings payments and risk settlements, and population-based payments.
- CurrentCare: supplemental Race and Ethnicity data.

Data can be used by healthcare consumers, researchers, providers, health insurers, and others to examine data on healthcare use, quality, and spending, and identify opportunities for improvement, such as measuring healthcare provider performance, tracking potentially preventable emergency room visits, and monitoring the growth of patient-centered medical homes.

The All Payer Claims Database is noted as having a budget that includes $475,129 in general revenue ($5.6 million in all funds) for the APCD[50].

The strength of the Rhode Island healthcare data system is the well-documented data sets it provides for consumers and researchers.

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[49] https://public.tableau.com/app/profile/onpointhealthdata/viz/APCDSnapshot-RhodeIsland/1_DataOverview accessed January 28, 2025
[50] Rhode Island Senate, Senate Fiscal Office Report, FY2023 Budget as enacted, October 11, 2022
https://www.rilegislature.gov/sfiscal/Budget%20Analyses/FY2023%20SFO%20Budget%20as%20Enacted.pdf

Texas

In Texas, the Center for Health Care Data is part of the University of Texas Health Science Center at Houston (UTHealth) and manages the All Payer Claims Database for Texas[51]. The database began as a need for researchers who wanted to have data for studying population health or the quality of healthcare delivery. Initially, they had grant money for funding. In 2021, legislation was passed in Texas officially setting them as the Texas All-Payer Claims Database (TX-APCE)[52]. The Texas Health and Human Services Department provides a series of data sets Texas Health Data, Center for Health Statistics, Vital Statistics Data, and Nursing Workforce Research.

The budget for fiscal year 2025 for the TX-APCE was $2.5 million per year. The budget document noted that "...for data analysis, including individual benchmark and progress data for each agency. As applicable, agencies shall collaborate on the development and implementation of potential value-based payment strategies, including opportunities for episode-based bundling and pay for quality initiatives.[53]"

The strength of the Texas system is that the APCD being housed in an academic setting allows the data to be leveraged not just for healthcare expenditure data but other healthcare research opportunities.

Utah

In Utah, the Health Data Committee was created by Utah Code 26-33a and is detailed in 26B, Chapter 8, part 5[54]. Parts of the Health Data Committee data governance have been in process since 1994. Members are appointed by the governor, confirmed by the Senate, and represent various perspectives from industry and the community—public health, purchasers, providers, payers, and patients. By law, members are required to have experience with health data[55]. Utah has the following healthcare data systems:

- Consumer Assessment of Healthcare Providers and Systems (CAHPS): Annual customer satisfaction surveys relating to health plan performance. This survey has been conducted by a private contractor. The survey does a random sample of enrollment. The survey includes Medicaid, commercial, and dental plans. The survey is about services and care that the members received in the last year.
- The Healthcare Effectiveness Data and Information Set (HEDIS®) - Annual quality measures relating to health plan performance. A report is published each year for Medicaid and Utah State Children's Health Insurance Program using HEDIS which is a set of nationally recognized performance measures used in monitoring the quality of care provided by health plans. The company that produces HEDIS is the National Committee for Quality Assurance (NCQA).
- Healthcare Facility Data - A collection of information about all inpatient, emergency room, and outpatient surgery/diagnostic procedures performed in the state. The Utah Department of Health and the Utah Health Data Committee developed a healthcare facility encounter database and began

[51] https://sph.uth.edu/research/centers/center-for-health-care-data/texas-all-payor-claims-database/ accessed January 28, 2025
[52] https://capitol.texas.gov/tlodocs/87R/billtext/pdf/HB02090F.pdf
[53] GENERAL APPROPRIATIONS ACT FOR THE 2024-25 BIENNIUM Eighty-eighth Texas Legislature Regular Session, 2023

[54] Utah Health Data Authority Act Sunset Overview, https://le.utah.gov/interim/2023/pdf/00002677.pdf
[55] https://healthcarestats.utah.gov/about/

collecting inpatient discharge from all licensed hospitals in Utah and the Veterans Administration Medical Center in 1992. In addition to these important data, ambulatory surgery and emergency department encounter data collection was established in 1996. These data represent nearly every hospitalization, emergency department visit, and ambulatory surgery in Utah for any given year regardless of payer[56]. All licensed ambulatory surgery centers, hospitals, and emergency departments in Utah submit encounter data to the Healthcare Facility Database. This includes billing, medical, and personal information.

- All Payer Claims Data - A collection of data about health care that is paid for by third parties, including insurers, plan administrators, and dental and pharmacy benefits plans. Currently, the Utah APCD has claims information from roughly 80% of Utahns. It includes all of the plans in commercial markets, except for the ERISA self-funded plans that have not opted in, and that have 2,500 or more beneficiaries. This means fully and self-insured employers (minus ERISA self-funded plans that have not opted in), third-party administrators, pharmacy benefit managers, and dental insurers. It includes ACA plans, Medicaid, and Medicare Advantage. We do not have complete data for Medicare parts A, B, & D at this time. Medicare parts A, B, & D ran from 2008 to 2016. The database contains information about diagnosis, procedures, costs, payment, patient demographics, and more.

No information on the APCD funding could be located on Utah's state government website.

The strength of Utah's data system is that the Health Data Committee data governance has been in process since 1994. Additionally, many of the data sets collected stretch back to the 1990's such as hospital inpatient data (1992) and Ambulatory and Emergency Department data (1996). The APCD data is available from 2013. Utah has an advanced collection of data including consumer experience.

Vermont

The Green Mountain Care Board (GMCB) is an independent five-member Board whose members are appointed by the Governor for six-year terms. The Board was created by the Vermont Legislature in 2011 through Act 48, Vermont's landmark health reform legislation[57]. The Vermont Statutes are Title 18: Health, Chapter 220: Green Mountain Care Board. (Cite as: 18 V.S.A. § 9372)

The purpose is specifically to create an independent board with the expressed goals of improving the health of the population; reducing the per-capita rate of growth in expenditures for health services in Vermont across all payers while ensuring that access to care and quality of care are not compromised; enhancing the patient and health care professional experience of care; recruiting and retaining high-quality health care professionals; and achieving administrative simplification in health care financing and delivery.

The Green Mountain Care Board does the following items:

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[56] https://healthcarestats.utah.gov/about-the-data/healthcare-facility-data/
[57] https://gmcboard.vermont.gov/board

- Produce a Hospital Budget by October 1 for the next year. In its review, the Board considers local healthcare needs and resources, utilization and quality data, hospital administrative costs, and other data, as well as presentations from hospitals and comments from members of the public[58].
- Rate Review of major medical health insurance premium rates in the insurance markets. In its review, the Board must determine whether a rate is affordable, promotes quality care and access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to Vermont law[59].
- Certificate of Need: New healthcare projects in Vermont must obtain a Certificate of Need (CON) from the Green Mountain Care Board prior to implementation. The CON process is intended to prevent unnecessary duplication of healthcare facilities and services, guide their establishment in order to best serve public needs, promote cost containment, and ensure the provision and equitable allocation of high-quality healthcare services and resources to all Vermonters[60].
- Accountable Care Organizations (ACOs) - enacted in 2016 and set up the "all-payer" model[61]. The All-Payer Model (APM) aims to shift payments from a fee-for-service to a payment system based on value, high-quality care, and good health outcomes at a lower cost[62].
- Vermont Health Care Uniform Reporting and Evaluation System (VHCURES) which is Vermont's all-payer claims database, and the Vermont Uniform Hospital Discharge Data System (VUHDDS) which is Vermont's hospital discharge database. In addition to these rich databases, the GMCB collects and uses a vast amount of data through its various regulatory functions.

The most current Annual Report includes Budget Information for GMCB totaling 8,539,233 base budget with a one-time addition of 620,000 for the implementation of the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES)[63].

The strength of the Vermont system is the All-Payer Model. This model has reached a maturity where outcome reports are showing some successes for the system goals. However, there are reports that point to difficulties the system is experiencing including tracking patients across providers and encouraging providers to participate.

Washington

Washington State Health Care Authority (HCA)[64] maintains a series of databases along with the Washington All Payer Claims Database. Washington is specifically looking at using value-based purchasing (VBP) to keep costs

[58] Vermont Green Mountain Care Board Hospital budget Review, September 2022
https://gmcboard.vermont.gov/sites/gmcb/files/documents/HospitalBudgetReview_Guide_20220929.pdf
[59] Vermont Green Mountain Care Board Health Insurance Premium Rate Review
https://gmcboard.vermont.gov/sites/gmcb/files/documents/RateReview_Guide_20220929.pdf
[60] Vermont Green Mouintain Care Board Certificate of Need Bulletin 001
https://gmcboard.vermont.gov/sites/gmcb/files/documents/Certificate%20of%20Need%20Bulletin%20001_2019.11.19.pdf
[61] Act No. 113, 2016 Summary sheet
https://legislature.vermont.gov/Documents/2016/Docs/ACTS/ACT113/ACT113%20Act%20Summary.pdf
[62] https://gmcboard.vermont.gov/payment-reform/APM
[63] Green Mountain Care Board AnnualReport for 2023 Submitted January 16, 2024 page 36,
https://gmcboard.vermont.gov/sites/gmcb/files/documents/GMCB%20Annual%20Report%20-%2001.16.2023%28A%29.pdf
[64] Statues for the Washington Department of Health were renamed in 2011 to the Washington State Health Care Authority.
https://app.leg.wa.gov/RCW/default.aspx?cite=43.70

down while having access to better health and better care. They provide a biennial report to the legislature[65]. In addition to the All Payer Claims Database, the HCA maintains data sets and reports for Apple Health (Medicaid), Behavioral Health, and Clinical Data Repository. Additional programs that provide regular data to the legislature include the Medicaid Transformation Project the Health Care Cost Transparency Board & Prescription Drug Affordability Board.

- Washington All-Payer Claims Database - The APCD collects information on all healthcare claims in Washington State including Medicaid, Medicare, and commercial (fully-insured) insurance plans. Exclusions include private employer-sponsored plans (plans covered by the Employee Retirement Income Security Act, or ERISA)[66] WA-APCD was established in 2014 with legislation (RCW 43.71) Office of Financial Management (OFM) to establish and create the database. The database was then transitioned to HCA.

In the 2019-2021 biennial budget, the Legislature appropriated approximately $1.1 million to OFM to continue operating and maintaining the WA-APCD from July 1, 2019, through December 31, 2019. The Legislature also appropriated $3.54 million to HCA to maintain and continue WA-APCD operations, contract with a new Lead Organization (LO), and provide data access to state agencies from January 1, 2020, through June 30, 2021[67].

The strength of Washington State is that it has a very robust data system. They are using the value-based purchasing ideal to drive data reports to inform policy.

Key Findings

Budgets vary for implementation. New Hampshire's database cost a couple of million to set up in 2008. Some databases are included in budgets for offices with broader functions, such as Connecticut which established the Office of Health Strategy to consolidate existing state resources. Connecticut's Office of Health Strategy is primarily focused on collecting and analyzing data, including the All Payer Claims Database, Patient Discharge Data, Prescription Drug Costs for specific high-cost drugs, a total cost of care model, hospital financial reporting, and healthcare benchmarking. Connecticut's Office of Health Strategy had an operating budget in FY 2021 of $6.1 million. In other states such as Washington; the Washington Health Care Authority also maintains the Medicaid/Medicare programs. In Vermont, a separate state entity maintains the databases. In Colorado, a private nonprofit maintains the APCD, but it reports to the Colorado Department of Health Care Policy and Financing. Each of these administrative funding and organization options is available to New Mexico.

In the quick survey of states, all noted that the cost drivers of database maintenance are the number of organizations required to report, and the type and detail of reporting required. Specifically the number of variables needed for collection. Incomplete data collection can be a problem if the data collected cannot be considered representative. Additionally, most recommend some legislative requirements for reporting data.

There are choices for managing various functions in-house or through vendors, and also the source of operational funding. Some states use vendors for collecting claims data and pay for collection and quarterly

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[65] Washington State All-Payer Claims Database and Lead Organization biennial report https://www.hca.wa.gov/assets/program/wa-apcd-performance-report-2022-03-02.pdf
[66] Paying for health and value, Health Care Authority's Long-term Value-based Purchasing Roadmap 2023-2027; February 2023, page 5
[67] https://www.hca.wa.gov/assets/program/wa-apcd-performance-report-2022-03-02.pdf page 6

extracts of the data. Some activities are state-funded, and some charge reporting entities through various mechanisms. New Hampshire split the cost of collecting healthcare data between two state entities with one collecting fees from the insurance community to recover costs. Colorado has a non-profit set up and is the state's vendor for their APCD which initially used grant money.

Data quality and data validation can be a challenge. Database design is important upon creation, because modifications of the database may require retraining of reporting agencies and hinder longer-term statistical analysis due to variations in data collection. Existing state databases can serve as useful models for database design.

Reviewing the different states' websites and published data, those states that had a governing committee or board such as Utah and Connecticut had better data outputs. Also, Maine and Maryland, which have healthcare data collection under one agency, seem to do a good job on data reports. There is no clear-cut cut perfect way to set up a healthcare expenditure database. However, reviewing what other states have accomplished can help New Mexico set up its own systems. All states have legislation around the collection of healthcare expenditures and often this data goes down to the individual care level. Many states have worked out ways to make the data available to healthcare researchers. This data should not be limited to producing just costs of healthcare but also healthcare outcomes. There should be data-sharing governance set up to protect confidentiality while still enabling research. In our survey responses, there was a comment regarding the ability to truly track costs and outcomes being difficult when linking information across different data sets. Reading up on Vermont, the difficulties the All-Payers-Model is having is linking data sets into their databases for analyzing healthcare outcomes. For example, for individuals, it's difficult to track clinical diagnoses, treatments, and outcomes across providers[68].

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[68] Despite Early Success, Vermont's All-Payer Waiver Faces Persistent Implementation Challenges: Lessons From The First Four Years", Health Affairs Blog, January 5, 2021 .
DOI: 10.1377/hblog20201222.153835 https://www.healthaffairs.org/content/forefront/despite-early-success-vermont-s-all-payer-waiver-faces-persistent-implementation#:~:text=In%202016%2C%20Vermont%20was%20granted,or%20public%20provision%20of%20services.
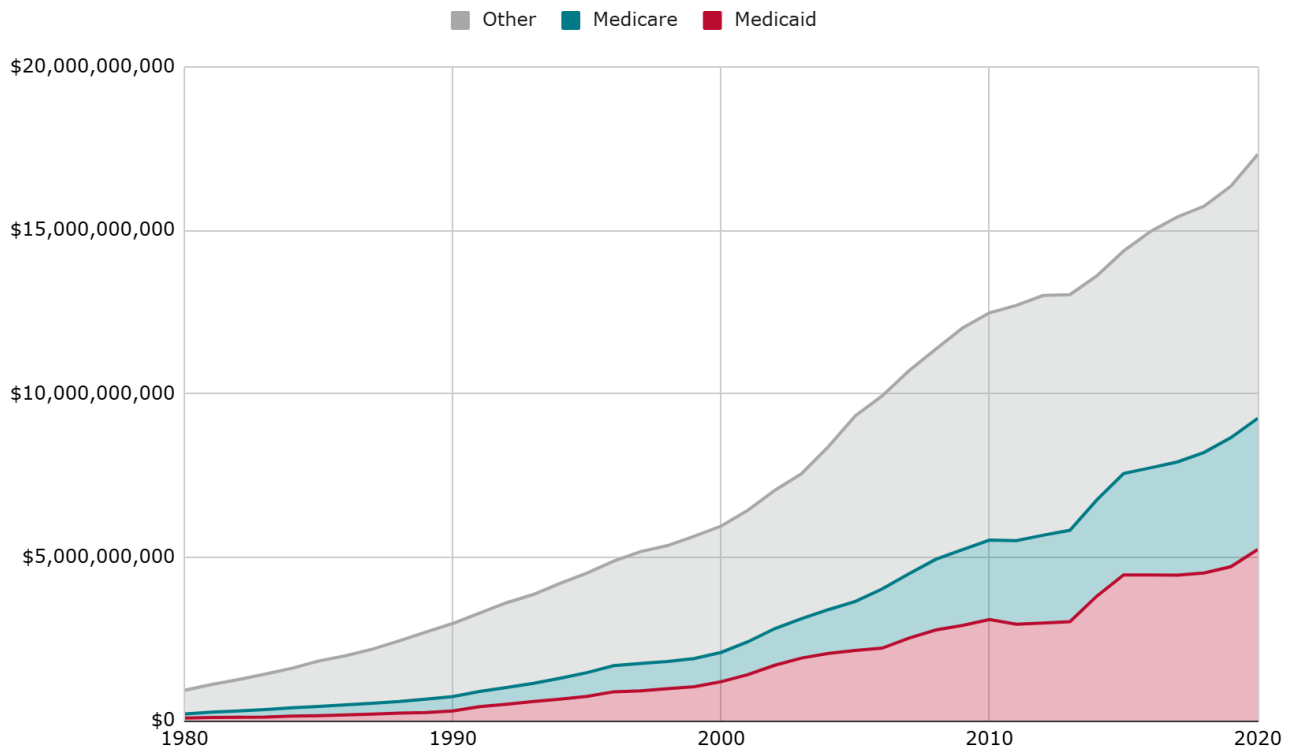
Data Sources

This section reviews healthcare expenditures data sources, discusses their strengths/weaknesses, and evaluates how well they represent New Mexico healthcare expenditures.

Publicly Available Data Sources

CMS National Health Expenditures (NHE) and State Health Expenditure Accounts (SHEA)

Centers for Medicare & Medicaid Services (CMS) annually publishes a data series that measures annual health spending in the U.S. by type of good or service delivered, source of funding for those services and sponsor. Data on projected spending are also available. Figures 4-7 show CMS personal health care spending data for New Mexico. Since 1980, personal healthcare expenditures have grown from $927 million to over $17 billion in 2020, with an annual growth rate of 7.6%, shown in Figure 4. Relative to GDP, personal healthcare expenditures have grown from 11% of New Mexico's GDP in 1998 to 17% of New Mexico's GDP in 2020, as shown in Figure 5.

Figure 5. Personal Health Care Expenditures by Provider, New Mexico 1980-2020[69]

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[69] Health expenditures by State of Provider https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/state-provider

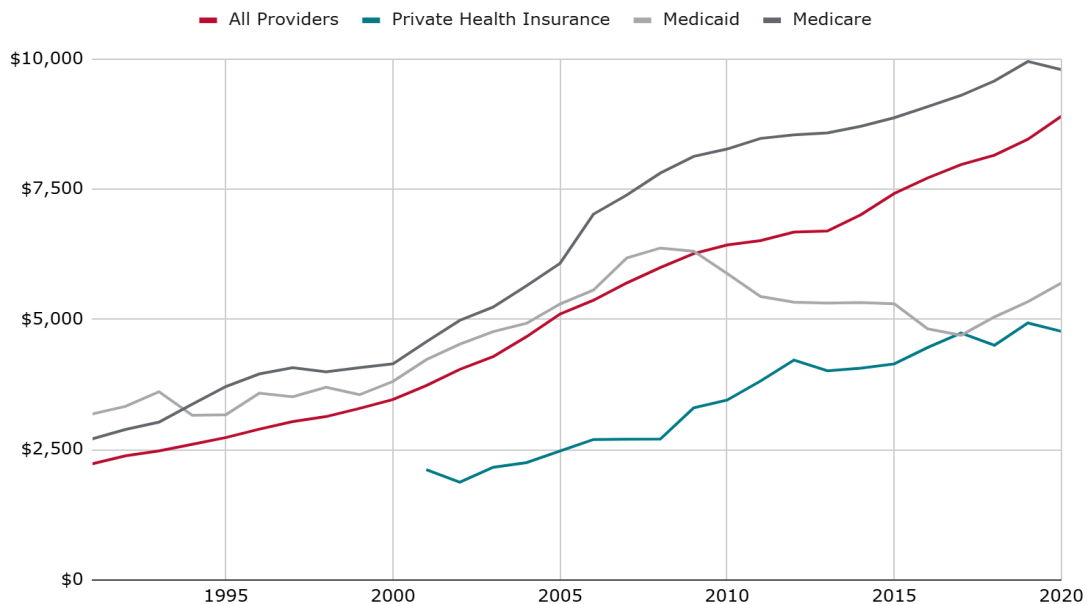*Figure 6. Personal Health Care Expenditures as a percentage of GDP, New Mexico 1998-2020[70]*
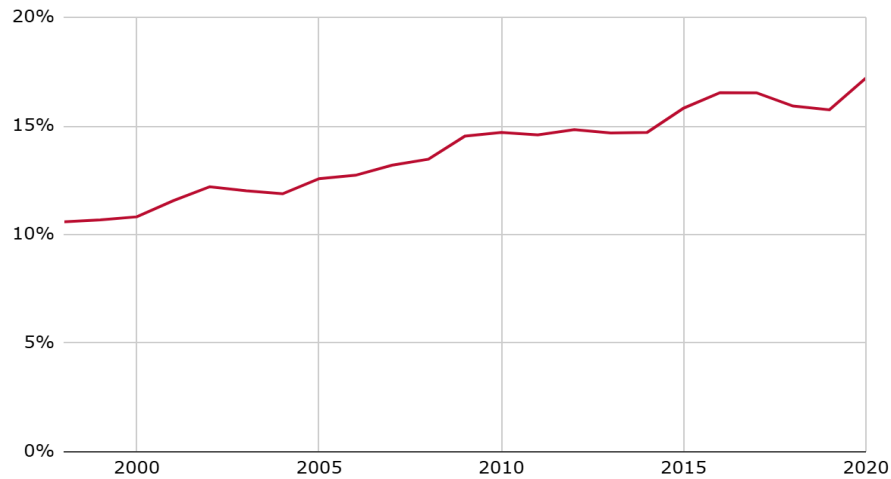
Per capita personal healthcare expenditures have also increased, growing from $2,228 per person in 1991 to $8,902 per person in 2020, as shown in Figure 6. As a percentage of per capita personal income, personal healthcare expenditures have increased from 15% of personal income in 1998 to 19% of personal income in 2020, as shown in Figure 7.

Figure 7. Per capita Personal Health Care Expenditures by Provider, New Mexico, 1991-2020[71]

[70] https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/state-provider & U.S. Bureau of Economic Analysis, "SASUMMARY State annual summary statistics: personal income, GDP, consumer spending, price indexes, and employment" (accessed Thursday, December 19, 2024).
[71] https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/state-residence

Figure 8. Per capita Personal Health Care Expenditures as a percentage of per capita personal income, New Mexico 1998-2020[72]
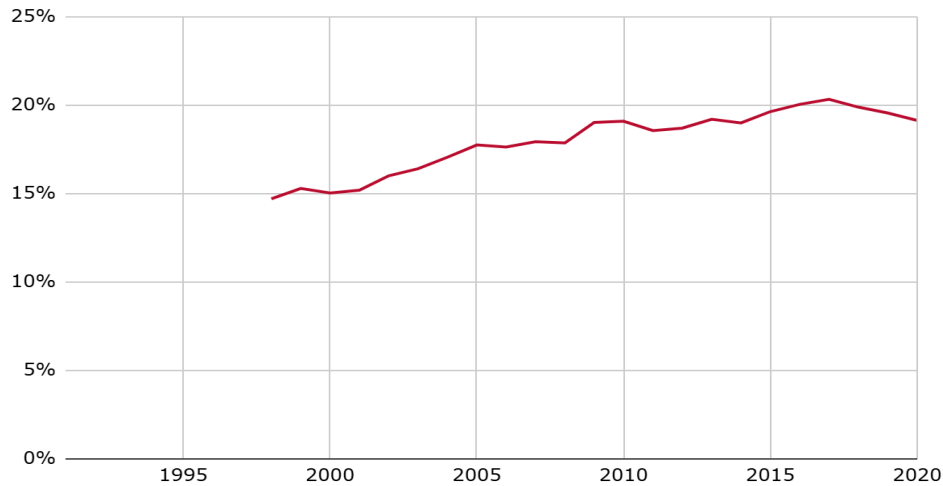
The strengths of the CMS dataset for state-level health expenditures are that it is publicly available at no cost, it has total expenditures since 1980, per capita figures since 1991, and private health insurance costs since 2001, plus the methodology is consistent across years and states allowing for comparisons over time and between states. Additional data is available at the state level for several important categories: Hospital Care, Physician & Clinical Services, Other Professional Services, Dental Services, Home Health Care, Prescription Drugs and Other Non-durable Medical Products, Durable Medical Products, Nursing Home Care, Other Health, Residential, and Personal Care. This allows for analysis of cost drivers to be analyzed for these individual categories across the entire state, which can be used to identify the categories contributing the most cost growth. The identified cost drivers could then be studied specifically or addressed through specific policy action.

The weakness of the dataset is that data takes several years to become available, currently, data is online and available through only 2020. This limits the ability of the dataset to inform quickly about healthcare costs. In some cases, state-level CMS data is based on estimates or models, rather than direct data collection which can lead to inaccuracies and generally less actionable insights that can be drawn from the dataset. Additionally, the data is not segmented by individual payers by market, and by advanced network (hospitals, primary care practices, and specialists). This limits the types of analysis that can be used to understand the cost drivers of healthcare in New Mexico. Additionally, data is not specific and timely enough to be used for cost benchmarking or global budgets.
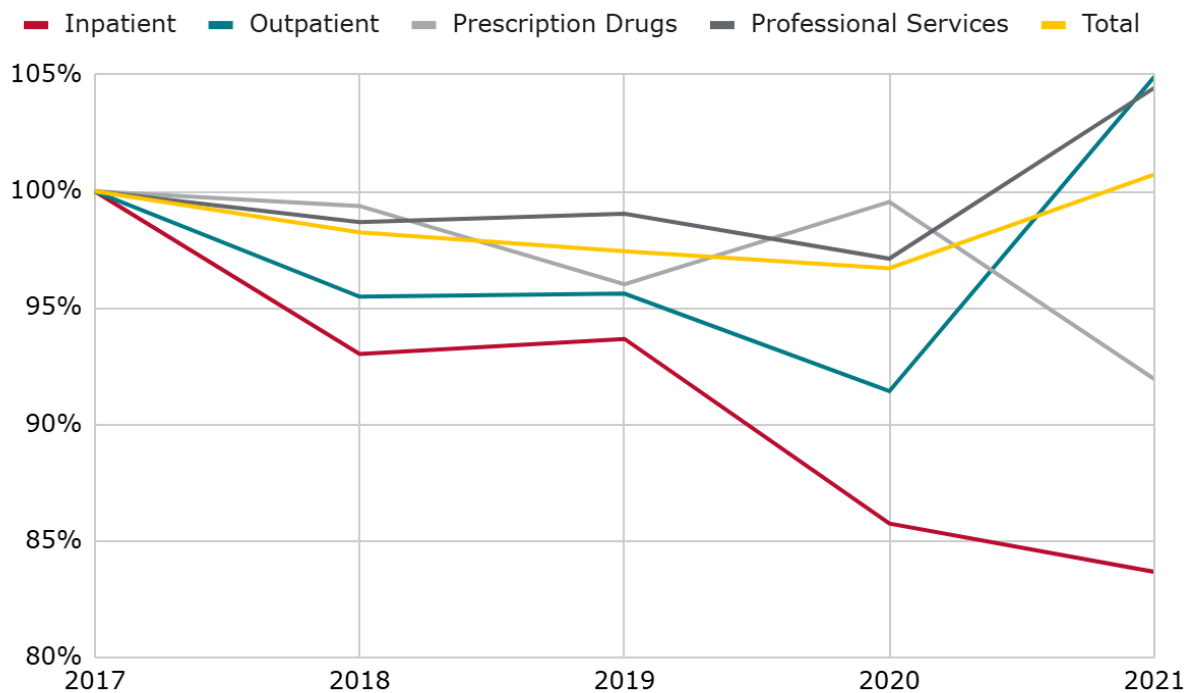
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[72] https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/state-residence & U.S. Bureau of Economic Analysis, "SASUMMARY State annual summary statistics: personal income, GDP, consumer spending, price indexes, and employment" (accessed Thursday, December 19, 2024).

Health Care Cost and Utilization Report (HCCUR)

The Health Care Cost Institute (HCCI) Health Care Cost and Utilization Report (HCCUR) provides trends in healthcare spending, utilization, and pricing for individuals based on available claims and encounter data. This data is not complete and is an extrapolation of data HCCI is able to collect from employer-sponsored insurance (ESI).[73] The report focuses on national trends across four broad service categories: hospital inpatient, hospital outpatient, professional (i.e., physician and other clinician) services, and pharmacy. Some state-level data is available and it can provide some information regarding trends in New Mexico.[74] Figure 8 shows that for New Mexico, in terms of utilization, Outpatient and Professional Services have been increasing, while Inpatient and Prescription Drug utilization has been decreasing. Overall utilization has increased slightly since 2017.

Figures 9 and 10 show healthcare spending and out-of-pocket spending by service category in New Mexico 2017-2021. During this period the fastest growing service categories since 2017 were Outpatient (+18%) and Professional Service (+10%) categories, in line with utilization trends. Overall health care spending increased 9% since 2017, while out-of-pocket spending declined 4%.

Figure 9. Healthcare Utilization in New Mexico by Service Category, 2017-2021[75]

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[73] https://healthcostinstitute.org/health-care-cost-and-utilization-report/annual-reports
[74] https://healthcostinstitute.org/hcci-originals/research-resources
[75] https://healthcostinstitute.org/hcci-originals/research-resources

Figure 10. Healthcare Spending in New Mexico by Service Category, 2017-2021[76]
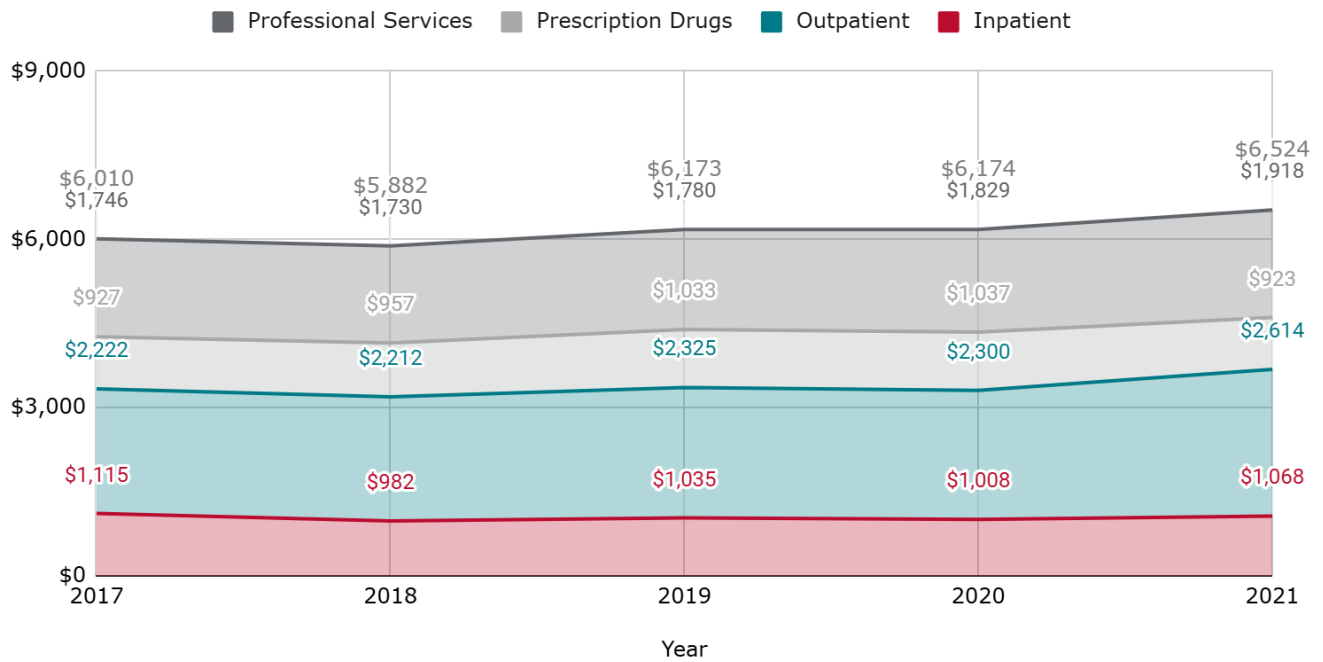
Figure 11. Out-of-pocket Healthcare Spending in New Mexico by Service Category, 2017-2021[77]

[76] https://healthcostinstitute.org/hcci-originals/research-resources
[77] https://healthcostinstitute.org/hcci-originals/research-resources
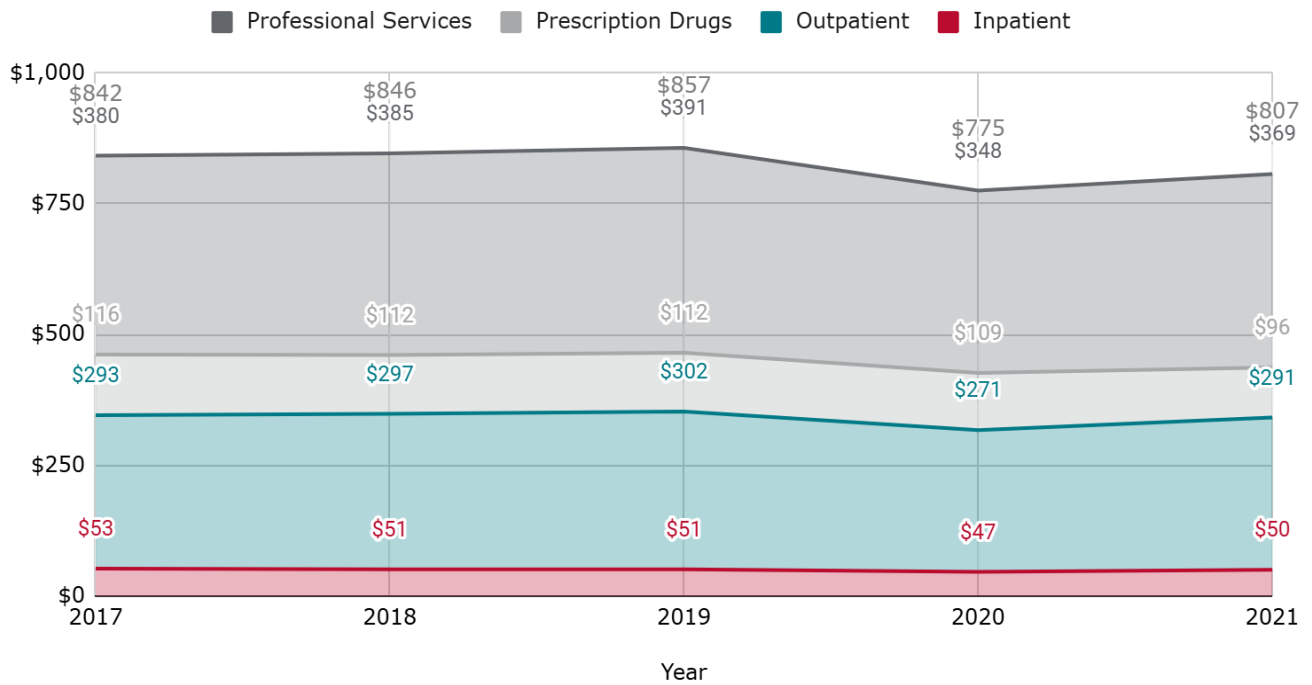
The strength of HCCI is that it is available annually so it is more timely than CMS data, and with claims-level data with demographic data, a wide range of claims-level analyses can be performed. The claims-level analysis makes it possible to understand detailed issues that typically would require an All Payer Claims Database to understand, such as service level price data that also has possible use cases for understanding cost drivers.[78] Utilization and spending figures may also highlight key cost drivers of healthcare that should be investigated further.

The primary weakness of HCCI data is that it is not complete and does not include insurance premium payments, although it does offer a useful estimation of healthcare spending based on ESI. This means it cannot be used to calculate total health expenditures by itself, and therefore cannot be a standalone source for a healthcare expenditure database, benchmarking efforts, or global budgets.

National Association of Insurance Commissioners (NAIC)

NAIC InsData[79] includes information from financial statements from over 4,800 insurance companies. Insurers are required to file annual and quarterly financial statements with the NAIC and their respective state departments of the insurer. NAIC compiles this information into data sets that are available for purchase. The Supplemental Health Care Exhibit (SHCE) includes detailed information on measures such as premiums and retention. In addition to the NAIC, the CCIIO MLR Reporting, provides similar data from insurers on aggregate premiums, retention, and membership, for commercial market plans.

The strength of this dataset is that it can provide the information necessary to calculate the net costs of private health insurance for individual insurance companies.

American Community Survey (ACS)

The American Community Survey (ACS) publicly available from the U.S. Census Bureau covers a variety of healthcare topics in addition to rich demographic data. Over the years the ACS added questions around health care coverage (2008) and premiums and subsidies in 2019. In New Mexico, in 2023 the ACS 1-year estimates for the civilian noninstitutionalized population show that 90.9 percent have healthcare insurance. The 9.1 percent without insurance represent approximately 188,600 individuals in New Mexico in 2023. The ACS has the U.S. healthcare coverage at 92.1 percent in 2023. The ACS also provides details about private and public healthcare insurance coverage. The following table shows how New Mexico compares to the U.S. There are some very notable statistics such as in 2023, 54.1% of New Mexicans have private health care insurance compared to 67.0% for the United States. In New Mexico, 52.2% of those with health care insurance coverage had public options but only 32.7% had only public coverage showing that many have both private and public coverage.

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[78] https://www.healthprices.org/
[79] https://content.naic.org/industry/insdata

Figure 12. New Mexico and U.S. Health Insurance Coverage Comparison, 2023

Health Insurance Coverage 2023	United States	New Mexico
Percent Insured	***92.1%***	***90.9%***
Private Coverage	67.0%	54.1%
Private Coverage alone	52.5%	37.0%
Employer-based health insurance alone	45.3%	31.9%
Direct-purchase health insurance alone	6.4%	4.1%
Subsidized marketplace coverage alone	1.9%	1.1%
Tricare/military health insurance alone	0.9%	1.0%
Public Coverage	37.4%	52.2%
Public Coverage alone	22.2%	32.7%
Medicare coverage alone	6.7%	7.2%
Medicaid/means-tested coverage alone	15.3%	25.2%
VA health care coverage alone	0.2%	0.3%

Source: U.S. Census Bureau American Community Survey 1-year estimates 2023 tables S2701, S2713 & S2704
https://data.census.gov/table/ACSST1Y2023.S2701?t=Health%20Insurance&g=040XX00US35
https://data.census.gov/table/ACSST1Y2023.S2704?t=Health%20Insurance&g=010XX00US_040XX00US35
https://data.census.gov/table/ACSST1Y2023.S2713?t=Health%20Insurance&g=010XX00US_040XX00US35

There is some poverty data associated with insurance type. The following table shows the percent below and at or above 138 percent of the poverty thresholds. This table illuminates the need for affordable health insurance. This data is certainly reflective of New Mexico's high level of 17.8% of poverty compared to the nation's 12.5% in 2023 ACS.

Figure 13. New Mexico and U.S. Health Insurance Coverage and Poverty Comparison

Health Insurance Coverage and Poverty	United States		New Mexico	
	Private	Public	Private	Public
Below 138 percent of the poverty threshold	30.2%	66.8%	21.6%	76.2%
At or above 138 percent of the poverty threshold	75.1%	31.1%	65.2%	44.1%

Note: numbers are for Alone or in Combination and do not sum to 100%
Source: U.S. Census Bureau American Community Survey 1-year estimates 2023.

The strengths of this data set are that it is easy to access; topics are population and household-based; updated annually and; available statewide and down to small areas using the 5-year estimates. The difficulty is that these data are survey-based and will have a large margin of error for small areas. Additionally, for Native

American Indian populations, those whose only health coverage was Indian Health Service were considered uninsured[80].

U.S. Bureau of Economic Analysis

The U.S. Bureau of Economic Analysis has several data series such as Personal Consumption Expenditures by type and Gross Domestic Product by industry. This data is often used in conjunction with other data. However, it is useful by itself in understanding the economic value of health care in New Mexico. The following table shows personal consumption expenditures for selected healthcare-related products. Of note, New Mexico outpatient services consumption of 37% is much lower than the 47% seen for the U.S. in 2023. To draw an interpretation will require more investigation; however outpatient services tend to be much cheaper and did experience less consumption expenditures in New Mexico than hospital services in 2023.

Figure 14. New Mexico and U.S. PCE Comparison by Product Type

Personal consumption expenditures (PCE) for the U.S. and New Mexico for selected type of product 1 *(millions of current dollars)*				
2023	**United States**	**%**	**New Mexico**	**%**
Health Care	**3,057,648.0**		**16,911.6**	
Outpatient Services	1,437,064.4	47%	6,289.9	37%
Physician Services	*734,840.6*		*2,683.8*	
Dental Services	*172,697.8*		*938.7*	
Paramedical Services	*529,526.0*		*2,667.5*	
Hospital and Nursing Home Services	1,620,583.6	53%	10,621.7	63%
Hospitals	*1,393,810.3*		*9,730.6*	
Nursing Homes	*226,773.3*		*891.0*	
Net Health Insurance	**258,892.4**		**2,430.6**	

1. All personal consumption expenditures (PCE) estimates are in millions of current dollars (not adjusted for inflation). Calculations are performed on unrounded data.
Last updated: October 3, 2024-- new statistics for 2023; revised statistics for 2019-2022.
Source: U.S. Bureau of Economic Analysis, "SAPCE3 Personal consumption expenditures (PCE) by state by type of product 1"

The BEA also publishes Gross Domestic Product (GDP) data. New Mexico had $9,666 million of GDP for Health care and social assistance in 2023.

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[80] American Community Survey and Puerto Rico Community Survey, 2023 Subject Definitions, page 82
https://www2.census.gov/programs-surveys/acs/tech_docs/subject_definitions/2023_ACSSubjectDefinitions.pdf

Figure 15. New Mexico and U.S. GDP Healthcare Comparison

SAGDP2N Gross Domestic Product (GDP) Selected Health Care Related Comparison *(millions of current dollars)*				
2023	**United States**	**%**	**New Mexico**	**%**
Health care and social assistance	**2,038,867**		**9,666**	
Ambulatory healthcare services	1,000,523	49%	4,253	44%
Hospitals	643,823	32%	3,153	33%
Nursing and residential care facilities	196,507	10%	807	8%
Social assistance	198,014	10%	1,454	15%
Insurance carriers and related activities*	**721,127**		**2,286**	

1. Gross Domestic Product (GDP) is in millions of current dollars (not adjusted for inflation). Industry detail is based on the 2017 North American Industry Classification System (NAICS). Calculations are performed on unrounded data.
* Healthcare insurance is not broken out in this data series
Source: U.S. Bureau of Economic Analysis

Data Sources for Collection

Healthcare expenditure databases collect claim payments, non-claim payments, and non-medical drivers of health costs. To gather all the data necessary for a healthcare expenditure database requires complete data from multiple sources noted under each of the following categories:

- Claim Payments can be drawn from an All Payer Claims Database if the data is complete. With complete data, the entire All Payer Claims Database can be totaled to calculate annual claim payments across all payer categories (private payers and public programs, including Medicare, Medicaid, state programs, commercial carriers, and self-insured employers).
- Non-claim Payments are compiled from several sources, most of which are available from insurance providers.
  - Prescription Drug Spending (less rebates) can be included in an All Payer Claims Database and if so this can be a good source. Additional sources include pharmacy benefit managers (PBMs) for claims data if not already included in the All Payer Claims Database, the manufacturer reports for rebates and discounts, Medicare Part D reports, Medicaid program data, and national datasets like those from IQVIA[81], which provides detailed insights into retail and non-retail drug spending trends.
  - Net costs of private health insurance are the difference between premiums earned and benefits incurred for insurance providers. This information can be gathered from state insurance regulatory filings and reports submitted to NAIC and available in the InsData database.[82] In some cases it may be possible to derive the net costs of private health insurance from SEC filings for publicly traded insurance companies, like Molina Healthcare[83], however, if the

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[81] https://www.iqvia.com/insights/the-iqvia-institute/reports-and-publications/reports/the-use-of-medicines-in-the-us-2024
[82] https://content.naic.org/industry/insdata
[83] https://www.sec.gov/edgar/browse/?CIK=1179929&owner=exclude

company operates in multiple states, state-specific data may not be available directly. Similarly, Form 990s for nonprofit insurance companies, like Presbyterian Healthcare[84], may potentially be used to calculate the net costs of private health insurance.

- o Provider Payments such as provider capitation payments and direct incentives to providers would also need to be included if not already collected by the All Payer Claims Database. The source for this data is typically insurance carriers, managed care organizations, or provider group financial reports.

- Non-Medical Drivers of Health Costs such as transportation if traveling more than 50 miles/45 minutes, to capture rural area access issues. Or maybe items around demographics, low income, educational attainment, housing, employment opportunities, or environmental factors.

Recommendations

Several approaches are available for maintaining a New Mexico-based healthcare expenditure database. Different levels of outsourcing are available with some tradeoffs. The current All Payer Claims Database (APCD) in New Mexico is a significant resource to utilize. The APCD can be aggregated to provide the bulk of the data required for a healthcare expenditure database. A key issue to consider with all-payer claims databases and all healthcare databases to be used for policymaking is the data quality and trustworthiness. This issue arose repeatedly in our study of other states. To address this issue, the best practices include mandatory reporting to get complete data, a common data layout that can be used to organize consistently, and quality assurance practices to clean data appropriately and work with reporting entities to complete reporting forms correctly. Common data layouts are available publicly from other states and should be leveraged when designing a common data layout for New Mexico. The All-Payer Claims Database Common Data Layout (APCD-CDL™) is a good place to start.[85] The current NM APCD uses a standard common data layout and has data integrity and auditing functions performed by an experienced contractor.

Regarding outsourcing options, some private companies offer data collection services or data subscriptions that can be utilized. The advantage of outsourcing is consistent and predictable data without requirements of data collection, and infrastructure to manage and securely store sensitive data. The disadvantage is provider switching can be difficult and costly, and data access may not be complete since typically only regular data extracts are provided instead of direct data access. The current NM APCD uses a contractor to provide extracts for Medicare and Medicaid data, however commercial payer data is collected directly and audited by the contractor.

Some entities in other states that have already invested in infrastructure and data collection and management operations may be available to partner with to take on some of these responsibilities for a fee. For example, the University of Texas at Houston has made a significant investment in building infrastructure and data collection and management operations to maintain an all-payer claims database for research and public health reporting in Texas and is available to offer similar services to other states on a contract basis. A partnership like this may offer more flexibility than is typically available with commercial partners. In our review of state databases, Connecticut stood out as a leader in healthcare data collection and analysis. At a minimum their publicly available documents, such as their Implementation Manual[86], such be studied closely for best practices. Additionally, partnership opportunities may be available to leverage their expertise and existing infrastructure.

Building and maintaining the database in New Mexico is another option. Leveraging the existing all-payer claims database is a good place to start, and consolidating management of the APCD and a healthcare expenditure database within a single unit may make sense and could offer cost savings due to the overlap. Connecticut used this approach with the creation of its Office of Health Strategy which houses its health databases. Other states house these databases in a state department, while others are located at research universities as in Texas. Managing the collection of data, data quality, database, and database infrastructure.

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[85] https://www.apcdcouncil.org/common-data-layout
[86] https://portal.ct.gov/ohs/-/media/ohs/cost-growth-benchmark/public-hearing/ct-ohs-cost-growth-and-primary-care-implementation-manual-v40-2024-10-4.pdf?rev=6c848a39c6ac497eac84567b7c9d26c8&hash=9C991A3440845F819B7CA355DAB41566

Given the sensitive nature of the health data, security, and privacy are significant concerns that must be addressed.

Arrowhead and BBER Proposal on NM-based Healthcare Expenditure Database

Arrowhead Center and BBER, based on our initial findings, believe that we could work on an implementation of the Healthcare Expenditure Database which would build on and supplement the existing All Payer Claims Database. Our goal would be to track the other parts of healthcare expenditures from the non-claim payments and non-medical drivers of healthcare costs that may not be captured in the NM APCD. We would need a year to determine the necessary data sources and items to collect as well as design how this additional data would best benefit the New Mexico healthcare data system. We are comfortable at an overall cost of $250,000 per year. Costs would be primarily salary and database/website hosting. BBER has experience with Amazon Web Services including database and estimated hosting costs based on historical costs. For the first year, the amount should be split evenly between the two entities. The second year's budget could be adjusted for expenses between Arrowhead Center and BBER.

We put forward this suggestion as a way to begin establishing a healthcare expenditure database. It has taken the state many years to implement an APCD through which they have had difficulties with funding and staff hiring. Having two research universities address the non-claim payments and non-medical drivers would sidestep these difficulties. It would also give our economists the opportunity to work with the state in a more structured advisory role in helping determine the cost drivers of health care in New Mexico and specifically the total healthcare expenditures paid by New Mexicans.

Appendix

Survey Responses

The following are the states that responded to our seven-question survey. Two of the states did internet meetings to discuss their healthcare database with us and we filled in the responses as best as possible.

NEW HAMPSHIRE

What was the cost to develop your healthcare database? (If you can provide breakouts for labor and equipment or even comment on the main cost drivers.)

NH first implemented in 2008 and the cost was a couple of million. Initially the primary cost driver was fixed costs for development. Now the variable costs are the driver and they are really the number of insurance carriers you have to collect data from, the number of variables you want to collect data on and the number of state regulated claims you have. Maine and NH implemented about the same time. We are also talking with Indiana and South Dakota who are in the process of implementing.

What annual costs are involved in maintaining the healthcare cost database?

We work with a vendor Milliman corporation who collects the claims database. They charge us a quarterly fee for the quarterly extract of about $110,000 (split between two agencies) an extract and a monthly $15,200 (split between two agencies) for monthly claims data collection.

Who is data being collected from? - Selected Choice

Insurance companies,Government agencies

What are the primary data points being captured?

CDL Common Data Layout see www.apcdcouncil.org/common-data-layout/. This collects a lot of radiancy in fields but is a standard that vendors use.

What are the goals for this database?

The biggest problem is that we do not have 100% coverage of all claims data. The goal would be to improve coverage. We collect data from some Self Insured, commercial, and some Medicare but not all. The legislative rules is what restricts/allows us to collect data see them at www.gencourt.state.nh.us/rules/state_agencies/ins4000.html . Opponents of this data collection often say that it is not representative.

What has been the biggest lessons you learned implementing the database?

It is important for good data collection for the carriers to buy into the system. In many cases insurance carriers are vilified as denying too many claims. This provides them some transparency and a way to produce real denial rates showing that maybe they are not as high as perceived and a reasonable way to compare with other states.

Any additional information you would like to share with us about Healthcare Expenditure Database development?

A secondary data set used but we don't collect is Hospital Discharge data.

Our funding is unique as some of the funding comes from the Insurance Department through premium collections. This has not increased NH premiums by very much. The other part comes from the state budget General Fund. Good contacts for additional conversation are Jason Aziz and Morgan Harris.

NEW JERSEY

How much did it cost to set up this database?

The cost of the current project for 9 years is about 2,940,000 and 2,040,000 for inpatient and outpatient, respectively. The total cost for 9 years is therefore 4,980,000.

What are the main cost drivers?

Each hospital that submits their data has paid directly to NJDOH's data repository intermediary. Therefore, NJDOH does not bear any specific cost for this project. If any new facility wants to submit data to NJDOH, it is required to pay an installment fee to the state's repository data intermediary in the data collection process.

When was the legislation passed?

The regulation to collect Hospital Uniform Billing Discharge Data was passed in 1981. See the detailed information about the regulation at Department of Health | Health Care Quality Assessment | NJ Hospital Discharge Data Collection System (NJDDCS).

Currently how much budget is requested for this project?

As indicated earlier, NJDOH does not bear the cost of maintaining, updating, and improving the database system except state employees who are handling the datasets. Hospitals should pay directly to the state's data repository intermediary.

Who is data being collected from? Hospitals, insurance companies, government agencies, individuals, doctors?

NJDOH has collected patient level claim data directly from general acute care hospitals and long-term acute care facilities. You can find the detailed information about those facilities from our data dictionary, Appendix C - NJ HealthCAP Data Dictionary and Extract File Layout_v3.0.pdf.

What data is being collected? What are the primary data points being captured?

The database includes three major components of hospital discharge claim data such as demographic, clinical, and revenue.

What are the goals for this database?

The goal is to provide the information for health researchers and professionals that is necessary to improve residents' health conditions. It is well known that the value of the hospital discharge database is to track across databases and is explained at acknowledgement_final.pub.

What has been the biggest lessons you learned implementing this?

Since NJDOH has collected hospital discharge data from the early 1980s, we have been going through several storage system changes such DB, mainstream computer, and SQL during the past years. In addition, NJDOH has been including more fields steadily in the data collection process. The basic format of the current system was started since 2008.

These system changes have therefore required training for each hospital in terms of adjusting their own data system accordingly. This system changes have therefore impacted on their data submission status for some hospitals during the past.

In addition, whenever there is especially an ownership change of facilities, they tend to have been delaying their data submissions that have caused a lower volume of their total submitted claims after the closure date.

Finally, checking the data quality issue is very challenging because the data datasets include many fields with a large volume of claims. We have therefore spent some time checking the data quality in the data collection process.

MINNESOTA

How much did it cost to set up this database?

Minnesota has had an APCD since 2008. I am not aware of any information on the set-up cost that is readily available.

What are the main cost drivers?

There are several cost drivers. The size of the database, number of organizations required to report, type of reporting the state wants to do. In MN, the main cost drivers are related to data collection and aggregation followed by reporting.

Currently how much budget is requested for this project?

In Minnesota, the MN APCD budget comes from an appropriation that is shared with several different legislative initiatives for the Health Economics Program and we are not able to separate the cost out currently. There are a number of reports which have aggregated this type of information for state APCDs. I suggest connecting with the National Association of Health Data Organizations for a more comprehensive look into this question. (https://www.nahdo.org/)

Who is data being collected from? Hospitals, insurance companies, government agencies, individuals, doctors?

Data is collected from health plans, third-party administrators, and pharmacy benefit managers.

What data is being collected? What are the primary data points being capture?

We collect enrollment information, pharmacy claims, and medical claims currently.

What are the goals for this database?

The goals of the MN APCD are to improve the understanding of health care trends and address challenges in public health, population health, health care markets, quality of care, and the rising cost of health care by

publishing summary data and reports, in addition to supporting legislative activities and other special evaluations of the health care system in Minnesota.

What has been the biggest lessons you learned implementing this?

Few folks remain at MDH from the time the MN APCD was implemented so we don't have any lessons to share for this question.

TEXAS

How much did it cost to set up this database?
The legislature didn't fund the database. It grew from Public Healthcare Centers- servers, staff time from center; Internal to the university and supplemented with grant research which had benefits from and APCD. Established but don't have funding.

What are the main cost drivers?

Staff and hardware.

Currently how much budget is requested for this project?

Need 9 million over 2 years. California started with 65 million or 5 years. Supplement with grants and other research data. Similar conversation over time. Because it's Internal to the university It's hard to convince the Legislative Cost and Quality. There is a need for Transparency and Public Health. Need a trusted Third Party to offer this information.

Who is data being collected from? Hospitals, insurance companies, government agencies, individuals, doctors? 200 payers in Texas + dental plans

What data is being collected? What are the primary data points being capture?

Common Data Layout requirement and Submit how to document.
https://sph.uth.edu/research/centers/center-for-health-care-data/texas-all-payor-claims-database/payor-registration-information

What are the goals for this database?

Primarily for public healthcare research but could be used for more.
2021 Legislation 2023 modifications HB2029 and Hospital
https://capitol.texas.gov/tlodocs/87R/billtext/pdf/HB02090I.pdf

https://capitol.texas.gov/BillLookup/Amendments.aspx?LegSess=87R&Bill=HB2090

What has been the biggest lessons you learned implementing this?

Secure hardware and submission portal, fields and data collection, data cleanup.
A team to oversee the data submission.

Documentation on how data are cleaned up and processed. Indexing and de-identified following over people over years and carriers

Proprietor data locks you into 1 system. Not easy to change.

New Mexico 2023 Annual Private Industry Employment

Industry	Estab.	Average Private Employment	Total Wage	Average Weekly Wage	Taxable Wages
Agriculture, forestry, Fishing & Hunting	941	9,512	$383,124,946	$775	$274,112,
Mining, Quarrying, Oil & Gas Extraction	1,061	23,551	$2,325,894,182	$1,899	$900,633,144
Utilities	292	4,250	$403,267,601	$1,825	$137,061,852
Construction	5,400	53,117	$3,444,040,538	$1,247	$1,846,547,075
Manufacturing	1,609	28,679	$1,859,982,675	$1,247	$898,874,558
Wholesale Trade	2,968	20,972	$1,514,163,359	$1,388	$664,553,668
Retail Trade	6,280	94,549	$3,393,575,283	$690	$2,318,541,514
Transportation & Warehousing	1,636	24,235	$1,411,917,727	$1,120	$756,407,643
Information	1,892	10,236	$763,655,860	$1,435	$342,612,629
Finance & Insurance	3,328	22,585	$1,761,539,566	$1,500	$720,440,678
Real Estate & Rental & Leasing	2,712	10,465	$548,163,580	$1,007	$311,244,518
Professional, Scientific, & Technical Services	8,729	68,252	$6,995,963,081	$1,971	$2,207,839,703
Management Of Companies & Enterprises	541	5,158	$479,716,972	$1,789	$205,585,811
Administrative & Support & Waste Management & Remediation Services	4,300	46,769	$2,421,296,930	$996	$1,454,487,940
Educational Services	1,172	11,370	$564,529,595	$955	$261,271,013
Health Care & Social Assistance	10,651	123,876	$6,347,496,004	$985	$2,581,283,615
Arts, Entertainment, & Recreation	853	10,859	$340,273,522	$603	$216,767,502
Accommodation & Food Services	4,454	88,962	$2,235,578,371	$483	$1,863,238,112
Other Services (except Public Administration)	4,561	21,301	$989,217,903	$893	$574,136,398

Source: NMDWS, Quarterly Census of Employment and Wages program. Downloaded: Mon Dec 16 2024 10:51:52 GMT-0700 (Mountain Standard Time)

Annual 2023 Health Care and Social Assistance by County

County	Average Annual Employment	Establishments	Total Wages	Average Weekly Wage	Taxable Wage	Contributions	Healthcare & Social Assist. % Employment All Industries
Bernalillo	51,645	3,897	$2,882,292,140	$1,073	$1,088,230,714	$7,440,523	18.40%
Catron		15					0.00%
Chaves	3,512	380	$157,993,218	$865	$88,981,488	$564,073	20.70%
Cibola	1,388	82	$60,494,854	$838	$22,706,105	$234,208	33.10%
Colfax	258	60	$10,216,032	$760	$4,962,112	$28,973	8.20%
Curry	3,407	200	$153,428,123	$866	$59,978,395	$362,834	23.50%
De Baca	44	6	$1,915,345	$845	$1,092,492	$11,927	15.70%
Doña Ana	16,116	1,209	$719,901,063	$859	$399,730,509	$2,508,604	27.30%
Eddy	2,577	146	$133,792,278	$998	$61,984,891	$445,649	9.40%
Grant	986	130	$42,846,688	$836	$26,649,774	$181,750	15.30%
Guadalupe	179	30	$9,515,181	$1,020	$4,951,137	$41,188	20.80%
Harding		2					0.00%
Hidalgo	138	22	$6,600,354	$918	$4,113,600	$28,300	17.20%
Lea	2,555	148	$125,276,147	$943	$49,911,935	$307,476	9.10%
Lincoln	599	79	$42,027,245	$1,349	$7,161,205	$44,173	10.70%
Los Alamos	932	92	$53,824,488	$1,111	$27,241,947	$153,907	4.70%
Luna	1,213	91	$50,590,474	$802	$28,495,174	$218,926	20.80%
McKinley	3,294	281	$110,956,252	$648	$59,830,882	$618,506	24.90%
Mora	139	38	$4,355,674	$602	$3,165,548	$30,734	37.90%
Otero	3,056	203	$156,422,437	$984	$44,571,373	$287,117	26.00%
Quay	354	53	$20,567,161	$1,116	$4,981,559	$53,886	19.40%
Rio Arriba	1,345	220	$80,615,920	$1,153	$21,915,984	$197,029	24.70%
Roosevelt	515	73	$18,574,705	$694	$12,737,422	$109,005	12.40%
San Juan	6,786	429	$361,432,756	$1,024	$118,726,142	$942,152	19.50%
San Miguel	1,759	262	$53,380,603	$584	$36,389,848	$238,709	37.90%
Sandoval	4,400	671	$196,906,169	$861	$84,552,560	$684,468	17.30%
Santa Fe	8,009	813	$553,289,273	$1,329	$151,132,829	$1,009,432	17.20%
Sierra	722	73	$29,348,123	$781	$12,913,115	$88,175	27.80%
Socorro	1,032	88	$41,533,482	$774	$13,651,444	$114,210	35.70%
Taos	1,726	175	$85,479,031	$953	$33,565,553	$252,590	19.30%
Torrance	304	67	$10,411,519	$658	$5,436,370	$32,272	13.80%
Union	173	15	$8,090,648	$902	$1,602,623	$5,985	21.00%
Valencia	2,878	337	$92,996,586	$621	$61,864,472	$590,392	21.50%

Source: NMDWS, Quarterly Census of Employment and Wages program. Downloaded: Mon Dec 16 2024 10:51:52 GMT-0700 (MST)

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Resource List of States Reviewed

State	Agency	Related Website	Statue Links
Colorado	Center for Improving Value in Health Care (CIVHC)	https://civhc.org/get-data/co-apcd-info/	https://civhc.org/wp-content/uploads/2022/01/CRS-25.5-1-204-2023.pdf
Connecticut	Office of Health Strategy	https://portal.ct.gov/ohs/services/data-and-reports/to-access-data/healthscore-ct?language=en_US	https://www.cga.ct.gov/current/pub/title_19a.htm
Maine	Maine Health Data Organization	https://www.comparemaine.org/	https://www.mainelegislature.org/legis/statutes/22/title22ch1683.pdf
Maryland	Maryland Insurance Administration	https://mhcc.maryland.gov/mhcc/pages/apcd/apcd_mcdb/apcd_mcdb.aspx	https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter12C
Massachusetts	Center for Health Information and Analysis (CHIA)	https://www.chiamass.gov/	https://malegislature.gov/Laws/GeneralLaws/PartI
Minnesota	Commissioner of Health	https://www.health.state.mn.us/data/apcd/index.html	https://www.revisor.mn.gov/statutes/part/HEALTH
New Hampshire	New Hampshire Insurance Department	https://nhhealthcost.nh.gov/	https://gc.nh.gov/rsa/html/NHTOC/NHTOC-X.htm
New Jersey	Department of Health	https://www.nj.gov/health/hcf/financial-reports/	https://lis.njleg.state.nj.us/nxt/gateway.dll?f=templates&fn=default.htm&vid=Publish:10.1048/Enu
New Mexico	Department of Health	https://apcd.doh.nm.gov/	
Oregon	Oregon Health Authority	https://www.oregon.gov/oha/hpa/hp/pages/cost-growth-target-reports.aspx	https://www.oregon.gov/oha/HPA/Pages/Statutes-Details.aspx?View={BF005535-B542-446F-B0B7-61328A304AEA}&SelectedID=10
Rhode Island	Department of Health	https://health.ri.gov/data/healthfactsri/	https://webserver.rilegislature.gov/Statutes/TITLE23/INDEX.HTM
Texas	The University of Texas Health Science Center at Houston (UTHealth)	https://sph.uth.edu/research/centers/center-for-health-care-data/texas-all-payor-claims-database/	https://statutes.capitol.texas.gov/Index.aspx
Utah	Department of Health and Human Services	https://healthcarestats.utah.gov/about-the-data/apcd/	https://le.utah.gov/xcode/Title26/26.html?v=C26_1800010118000101
Vermont	Green Mountain Care Board	https://gmcboard.vermont.gov/APCD-snapshot	https://legislature.vermont.gov/statutes/section/18/220/09372
Washington	Washington State Health Care Authority	https://www.hca.wa.gov/about-hca/data-and-reports	https://app.leg.wa.gov/RCW/default.aspx?cite=43.70