CENTER FOR SOCIAL POLICY

Analysis of the Medical Claims and Billing System in New Mexico

Findings from Focus Groups of Claims Professionals and Clinicians

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NOTES & DISCLAIMER:

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Executive Summary

The New Mexico Legislative Council Service commissioned The University of New Mexico Center for Social Policy (UNM CSP) to conduct a research study with health care professionals whose work includes oversight and processing medical billing on behalf of the State of New Mexico's Legislative Council Service. Our primary research questions include:

- How much staffing, and infrastructure currently exists within different health facilities and how much is needed to effectively manage patient loads?
- How much time is needed and spent in each respective step during the billing, coding, and claims processes?
- What differences do staff and clinicians observe in terms of billing, coding, and claims by different insurance companies, plans, and types?
- What impact do the current billing, coding, and claims systems have on patient care and clinician well-being?

Our team analyzed qualitative focus group and interview data from a total of 31 claims and clinical workers employed at various health facilities across New Mexico. To address our above listed research questions, participants were asked questions about how much time is spent on claims related tasks; staffing and claims infrastructure within their respective facilities and whether they were sufficient to process current claims loads; insurance specific challenges they face; and how billing and insurance related tasks impact patient care. The focus group and interview data were analyzed using thematic analysis, to identify broad themes and to identify commonalities across facilities by health facility type and geographic location.

Our findings showed that the medical billing revenue cycle, which is the process that manages all financial aspects of patient care, is highly complex and time intensive which has adverse impacts on patient care and clinician well-being. While some facility-specific solutions are helpful in streamlining billing and making it more efficient, systemic problems that include frequently changing and stringent rules and guidelines imposed by insurance companies and federal agencies dictate how care is provided. Some solutions, such as outsourcing billing and health care claims more generally seem to cause more problems rather than making billing more efficient or cost effective.

Billing and claims are more difficult for more complex and specialized care and in rural areas across the state. First, as participants noted, highly specialized care, that also tends to be more costly, often requires clinicians to receive prior authorization from insurance companies before any care, treatment, or medication can be administered or prescribed, adding excessive time and paperwork before patients can be seen, which is a challenge in a state where patients experience long wait times and/or are even unable to see specialists due to staffing shortages and overburdened health systems.

Second, rural communities, in particular those serving low-income populations, struggle with issues of in- and out-of-network providers that require patients to either travel all the way to Albuquerque or other towns and cities to receive in-network care or pay out of pocket – a

cost they cannot bear. Furthermore, with smaller facilities in rural contexts that serve lower income populations that often rely on Medicaid for insurance (and the low reimbursement rates that Medicaid often pays for procedures and care performed), it is financially difficult to stay afloat. Finally, one common theme we observed among participants working especially in the behavioral and mental health field, is that both prior authorization and formulary requirements not only delay effective and evidence-based patient care, but even obstruct it.

Based on the information we learned through the focus group and interview participants as well as background research we conducted, we suggest several recommendations that we believe can address several of the challenges identified from the participants. This ranges from short-term interventions to larger and long-term structural solutions that may drastically improve patient care and outcomes. For example, prior authorizations need to be streamlined and simplified. The prevalence of peer-to-peer authorization requirements overburden clinicians who try to treat patients using evidence-based care, and take time away from actual interaction with patients. Some insurance companies are already voluntarily addressing this issue by cutting the number of peer-to-peer requirements and streamlining prior authorization although the changes will not go into effect until next year. Second, requirements such as self-attestation, asking clinicians to set up a treatment plan with their patients, and including questions on various medically unnecessary patient information need to be scaled back or simplified to reduce physician time spent on this process. Third, is to consider structural change to the billing system in the state. Our discussions with health care workers made the need for a system level change clear. Fortunately, a number of alternatives exist, including the New Mexico Health Security Plan, that would offer comprehensive health care coverage to New Mexico residents and control costs. We expand on these interventions in the conclusion of the report.

Introduction

The University of New Mexico (UNM) Center for Social Policy (CSP) was commissioned by the New Mexico Legislative Council Service to conduct a research study on medical billing and claims in the state. The primary purpose of this study is to analyze the billing and claims process in New Mexico from the perspective of the healthcare professionals who work on billing related issues as part of their regular work duties. Our study focused specifically on how much time and energy clinicians spend on billing related issues that may take valuable time away from interacting with patients. Our report highlights several challenges that exist under the current system including how it impacts patient care and clinicians who work with patients, explore both universal and regionally- and facility-specific challenges, and to offer insights based on original data collection we conducted.

To guide our research, we engaged healthcare professionals in focus group discussions to address the following themes that organized our interviews.

- How much staffing, and overall infrastructure do different health facilities across the state currently have, and what are the ideal levels of both required to effectively manage patient loads?
- How much time is invested in each respective steps of the billing, coding, and claims processes across the state?
- How does the type of insurance coverage patients have in New Mexico impact the billing, coding, and claims process?
- What impact do the current billing, coding, and claims systems have on patient care and the satisfaction levels of healthcare professionals in the state?

To accomplish this, our team worked in partnership with BSP Research to collect survey and qualitative data across New Mexico. In total, 31 participants were recruited for focus groups and semi-structured, one-on-one interviews, from across the state who work at health facilities in clinical, administrative, and/or billing and claims capacities. Our team focused recruitment on medical professionals who do billing and insurance related tasks on a day-to-day or regular basis.

The following report is structured as follows:

- The report opens with a glossary to ensure readability for audiences who are not extensively familiar with the revenue cycle and billing and insurance related tasks in health care. For readers that are more familiar with this aspect of healthcare, we recommend skipping to the next section.
- We describe the data we collected and a provide a brief description of how we analyzed it.
- We summarize our findings, including that billing and insurance related tasks are time intensive and complex and require a specialized skill among staff to execute, and an overview of how much time is spent for specific stages in the revenue cycle and/or on specific insurance related tasks. The report identifies areas in the system that require

further attention or resources and provides suggestions for changes and explains facility-specific solutions where appropriate.

We follow our findings with recommendations based off our data and next steps we believe are needed for additional research that can motivate policy changes. We close the report out with an appendix that includes the focus group and interview scripts.

Glossary

The following report includes a number of specialized terms that may be difficult to follow for readers who are not experienced with medical billing, or health care and insurance companies in the United States. We provide an alphabetical glossary of terms and will clarify in the report as institutions or rules are mentioned. For readers of this report that are familiar with the revenue cycle in healthcare and billing and claims related terminology, we recommend skipping this section.

Billing in the context of this report is used to encompass the entire process of submitting claims to both insurance companies and patients. Claims on the other hand, as explained below, are the part of the process focused on sending invoices to insurance companies.

Centers for Medicare and Medicaid Services (CMS) is a federal agency that oversees Medicare and oversees the federal portion of Medicaid and the Children's Health Insurance Program (CHIP). Within the context of this report, CMS was referenced multiple times in relation to the requirements it sets, such as self-attestation, which requires clinicians to certify the completeness and accuracy of the information they are providing.

Claims or Medical Claims are invoices that the health facility that provided patient care sends to the insurance company of patients. Claims list codes that describe the care that patients received.

Codes or Coding refers to the process of translating a patient interaction into numbers that insurance companies use. Codes are standardized and updated frequently. More information on the specific types of codes referenced in this report will be listed below.

Current Procedural Terminology (CPT) codes are a standardized numeric system to record a type of medical service for billing. These codes are maintained by the American Medical Association and are usually five-digit numeric codes.

Denials are claims that were evaluated and denied based on a patient's policy.

Electronic Medical Records (EMR) is an electronic record of a patient's health-related information within one health care organization.

Formulary is a list of preferred prescription medicines covered by an insurance plan and sorts drugs into different tiers based on how much they cost and how one's health plan covers. Formulary is updated at least once a year and differs by insurance company.

Healthcare Common Procedure Coding System (HCPCS) codes are similar to the above-mentioned CPT codes, as in that they are a standardized system to record a medical service for billing. Unlike the CPS, however, HCPCS is maintained by CMS, may include letters and numbers, and has two levels. HCPCS is also more expansive than CPT codes in the range of services listed.

International Codes of Diseases (ICD) are used to codify health conditions and diseases and procedures usually used in hospital settings and is administered by the World Health Organization (WHO). The United States is currently using ICD-10, released in 2015, while much of the rest of the world uses ICD-11. The ICD is updated twice a year, with major revisions occurring every ten years.

Managed Care Organizations (MCOs) are organizations that practice managed care principles which are "a health care delivery system organized to manage cost, utilization, and quality."[1] Examples include Blue Cross Blue Shield and Presbyterian.

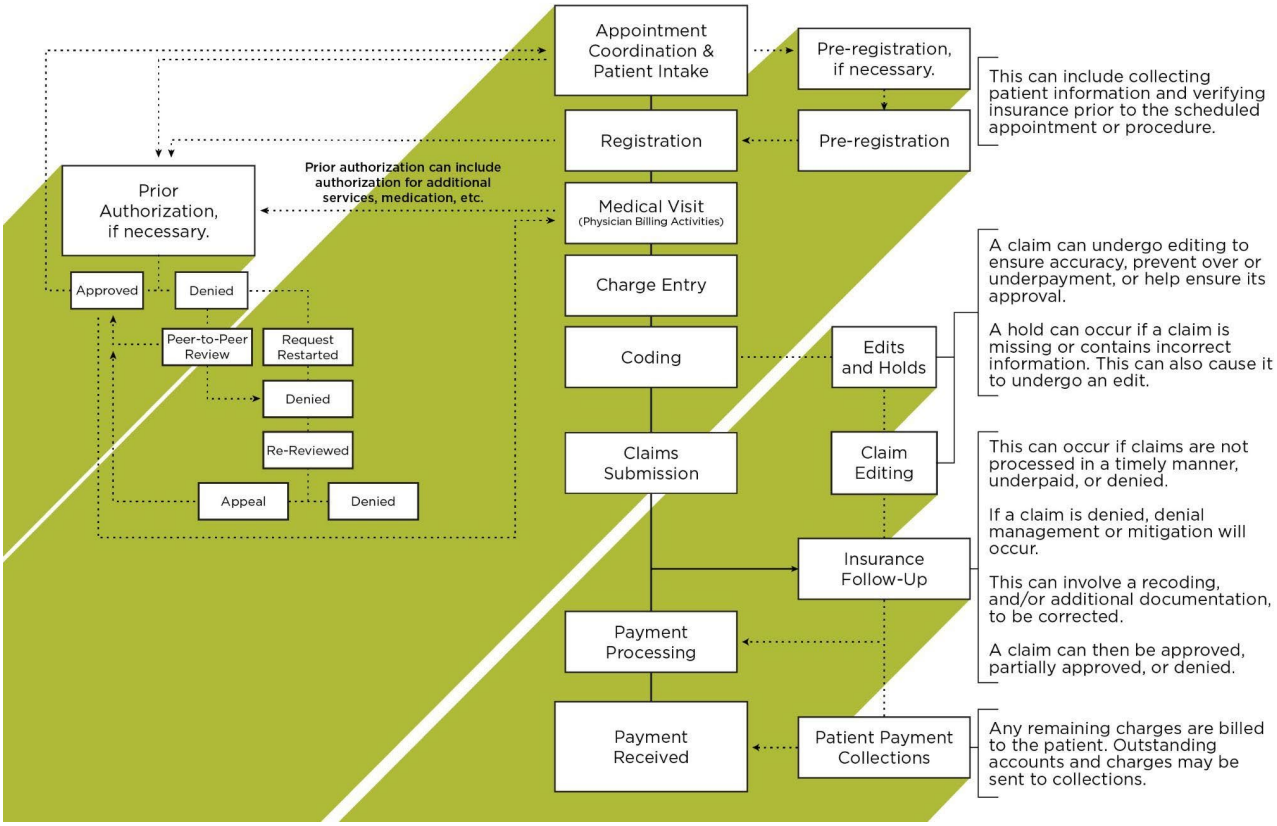
Peer-to-peer requirement (P2P) are discussions between physician and an insurance company doctor during the prior authorization process, and have, according to some participants, increased in recent times. The P2P discussion involves the physician justifying the medical necessity of a treatment, procedure, and/or drug they are trying to get approved by patients' insurance companies and happens before patients are seen and/or treated.

Prior authorization (PA) requires providers to receive approval from a patient's insurance company before they can administer a certain medication, treatment, or care to ensure it is covered. According to participants, prior authorization is usually required for more specialized and costly care.

Rejections are claims that are returned before they could be processed due to errors.

The **Revenue Cycle** in healthcare includes every administrative and clinical process that is a part of collecting payment for patient services provided. Since this process is convoluted and lengthy, as will be evident in the findings section of the report below, we mapped out this process using both the findings from our interviews and previous studies including Tseng et al (2018).[2] We also added prior authorization, which is not necessarily part of the revenue cycle but another important consideration within the process.

[1] Medicaid.gov (n.d.) *Managed Care*. Retrieved from: https://www.medicaid.gov/medicaid/managed-care
[2] Tseng, P., R.S. Kaplan, B.D. Richman, M.A. Shah, K.A. Schulman (2018). Administrative Costs Associated with Physician Billing and Insurance-Related Activities at an Academic Health Care System. *JAMA 319*(7), 691-697.



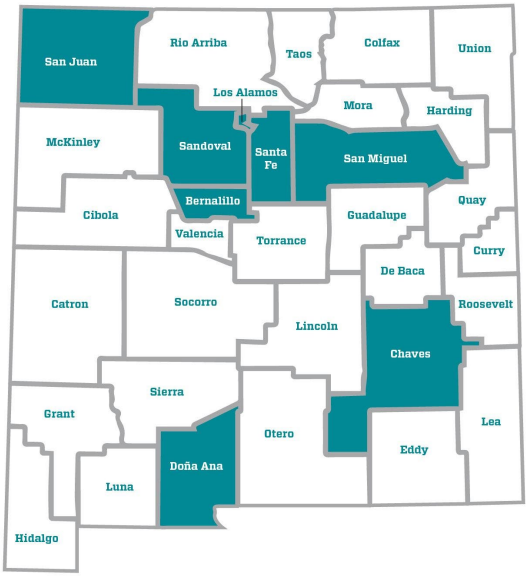
The Data Collection Process

Our research design for the project focused on learning more about the medical billing process in New Mexico, and the billing system more broadly, from the perspective of healthcare professionals who work in these areas. Our team partnered with BSP Research to conduct focus groups in New Mexico among healthcare professionals. We recruited professionals working in the medical field to participate in either a two-hour long focus group or a one-on-one interview. In order to be eligible to participate, participants had to reside and work in New Mexico, and work at a health facility where they completed tasks related to billing and insurance. Given the nature of our research questions, we wanted to recruit a wide range of medical professionals who had varied experience working on billing as their primary area of specialization, including medical professionals whose primary duty is to serve patients directly (including physicians and nurses).

The participants ranged in their involvement in the billing and claims process:

- Workers whose primary work duties were billing and claims related (with job titles such as claims, billing, financial specialists, etc.)
- Clinicians who do billing and claims related work (that include prior authorization, charting, etc.) on top of their primary work which was usually patient-facing.
- Healthcare workers in leadership/administrative positions who were involved in the billing and claims process to varying degrees.

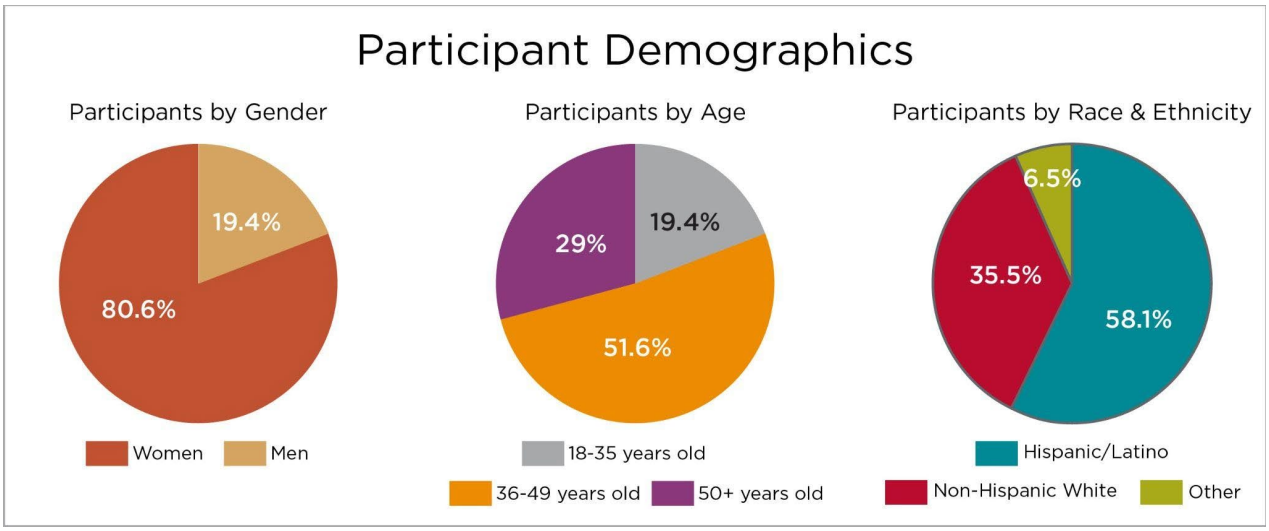
Our four focus groups were conducted in late May and early June 2025 between 6-8pm Mountain Daylight Time to accommodate participants' work schedules and were conducted virtually to minimize participants' time investment. Interviews were scheduled for participants who were unable to meet during the regularly scheduled focus groups. All focus group and interview participants filled out an in-take survey to capture where and what type of facility they worked, how much time is spent on billing and insurance related activities, and the demographic groups they identify with. All participants were compensated for their time.



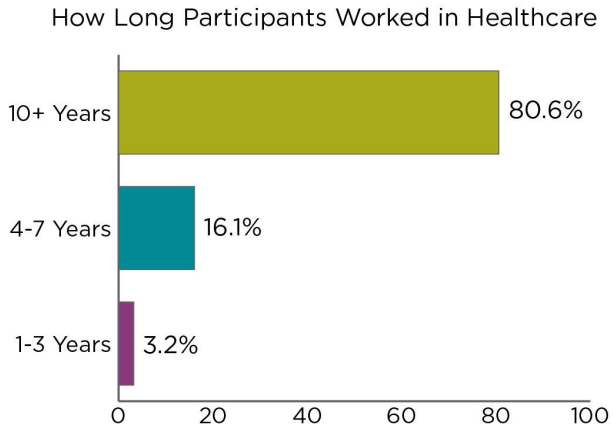
In total, we spoke to 31 people – 28 in focus groups and 3 in one-on-one interviews. One of our goals with recruitment was to ensure we had participants who serve New Mexicans who live in rural areas of the state. Our recruitment strategy allowed us to speak to participants whose facilities are located in eight counties in New Mexico that span urban, suburban, and rural communities. As the map below shows, we spoke to health facility workers in Bernalillo, Chaves, Doña Ana, Los Alamos, San Juan, San Miguel, Sandoval, and Santa Fe county. Our sample also included hospital workers who noted that they serve patients from all counties in New Mexico and even neighboring states.

We also asked participants demographic questions, the type of facility where they work, and the amount of time they spend on billing related tasks. These questions were asked to ensure that we had a larger share of hospital workers, understood what demographic groups were in the sample – and where possible, analyze differences in attitudes and experiences by different demographic groups – and ensured that participants engaged in billing related tasks on a regular basis. The pie graphs below show an overview of the demographic groups participants identify with. As reflected in the figure below, our sample was disproportionately female (which is in line with their actual representation in this workforce) – women (80.6%), and men (19.4%). Regarding race and ethnicity, 59.1% of our participants identified as Hispanic or Latino, 35.5% as non-Hispanic White, and 6.5% as other.[3] Additionally, in regard to age, 19.4% of participants were between the age of 18-35, 51.6% between the age of 36-49, and 29.0% were 50 years and older.

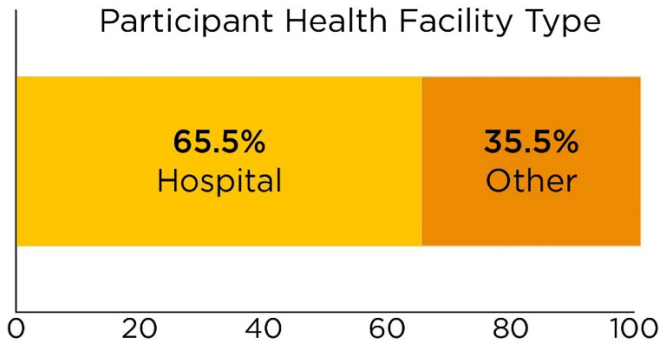
[3] The percentages may not add up to or exceed to 100% due to rounding errors.



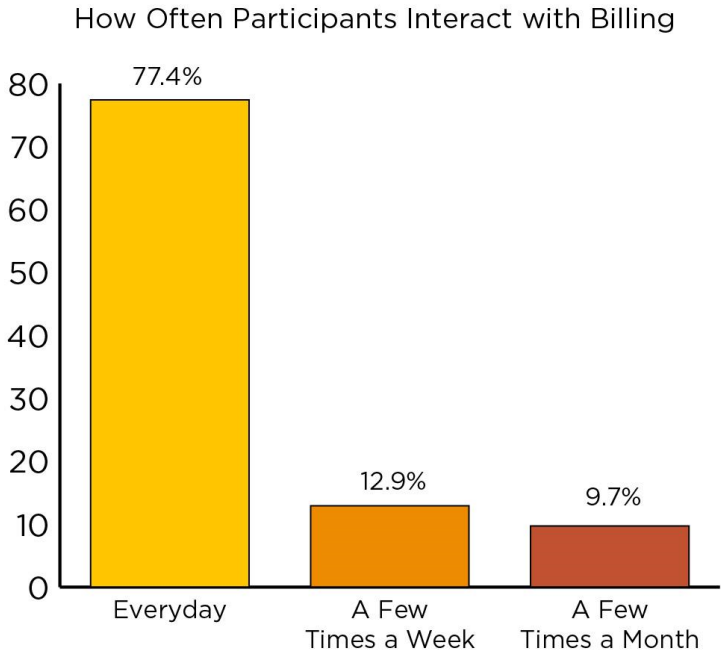
We also asked respondents to provide information about their job experiences, including how long they have worked in billing. Most respondents had worked in healthcare for a long period of time, with 80.6% of participants having worked in the field for 10 years or more. Another 16.1% had worked between 4-7 years in health care, and 3.2% had worked in the field for 1-3 years.



Our goal was to focus on hospital workers in particular, but to also capture workers in different types of facilities. In total, 64.5% of our participants worked in hospital settings, while 35.5% worked in other types of facilities, such as private practice.



Finally, we asked participants how often they engaged in billing-related activity. 77.4% stated that they engaged in billing activity every day (which includes both clinicians and billing and claims staff), 12.9% a few times a week, and 9.7% noted a few times a month.



Our research team conducted background research on the revenue cycle, medical billing, coding, and claims, and alternative models in advance of the sessions to improve the quality of the script used to guide our discussions. This included discussions with experts in this area and review of relevant academic literature.

The focus group and interview scripts were tailored to participants' primary work responsibilities, with a group specific to professionals for whom billing and claims are the primary focus of our job duties. For the clinicians we spoke to, our questions focused more on how much time they spend on billing and insurance related tasks, what types of challenges they encountered with different insurances, and how and if this type of work interfered with providing patient care. The content was created by the UNM CSP team in consultation with

BSP Research and the complete questions are listed in the Appendix. Follow-up and clarifying questions were asked as needed, since certain issues, such as prior authorization, were extensively discussed especially among clinicians for which we had not prepared questions.

All interviews and focus groups were facilitated by BSP Research who worked with our team to recruit healthcare professionals and schedule sessions based on the availability of respondents. BSP provided an on-line platform to house the groups and facilitated recordings and technical assistance. The moderation was co-facilitated by our team and BSP with Ph.D.-level moderators with extensive experience in focus group and interview facilitation with medical professionals. Due to the sensitive nature of the content asked, all data presented is de-identified, meaning that we do not identify workplaces or names or any other identifying information in this report. The focus group and interview data are analyzed using thematic analysis. We identified broad patterns across participants and health facilities, and noted organizational- and location-specific challenges that participants observed.

Findings

Billing and Insurance Related Tasks are Time Intensive and Complex

The focus groups data consistently revealed that across health facilities in New Mexico, the revenue cycle is complex and time intensive even for members of the workforce who have worked in the system for several years and are designated staff that work in billing, coding, and claims. This makes the challenge of having to engage in this area of the system even more glaring for clinicians whose primary responsibility is patient care. Our findings show that some processes are more time intensive and complex, and the entirety of the revenue cycle in most organizations encompasses a number of staff – and depending on the size of the health facility – multiple large and difficult to identify and navigate departments. This fragmentation and complexity lead to confusion and unnecessary delays. Furthermore, frequent rule changes, that include updates from insurance companies, the American Medical Association, the Centers for Medicaid and Medicare Services, and the World Health Organization add time and complexity to the process. This leads to frequent code changes.

How Much Time is Spent on Medical Billing?

Research participants frequently emphasized how time-consuming billing and insurance related tasks are in general, particularly for clinicians, whose primary responsibility is patient care. This may be one of the most important findings from the study, as it strongly suggests the need to consider reforms that will allow clinicians to focus their time with patients. Respondents were asked how much time they used on billing and insurance related tasks in their average work week. While physicians noted that they spend around 3-4 hours a week on billing and insurance related tasks, they all also found that it is difficult to disentangle and be explicit about how much time exactly is spent because a lot of this process happens subconsciously (which could also lead to miscommunication) and varies depending on the patient and the complexity of treatment and care they require.

Below, we explain the different processes that are time consuming at each stage of a patient encounter, including before seeing patients, during the patient encounter, and post-appointment.

Before Patient Encounters

Prior authorization, which is the approval that clinicians need to obtain from insurance companies to administer specific treatments, infusions, and/or care, can occur before patients are seen at all – if they are trying to see a specific type of specialist – or at any point while patients are treated if said care is not covered (or no longer covered) by their insurance.

The nurses we spoke with noted that they spend a lot more time than physicians on billing and insurance related tasks, and that this does interfere with their ability to provide patient care. One respondent said that prior authorization can take up most of a workday, leading to vast delays in time spent caring for patients. Workforce members explained that a lot of time is spent on phone calls trying to sort through issues and that prior authorization response time from insurance companies is between 7-14 business days, but that required modifications or fixes mean that this clock often is re-started leading to delays.

When asked how long it can take for prior authorization to finally be approved, participants explained that it can take weeks to months, which significantly delays care.[4] The nurses we spoke to spend at the very least two hours a week on prior authorization, and as much as four hours a day for four days straight trying to get care authorized by insurance companies for a single patient. Some of this may also be because of how difficult it is, according to the participants, to get ahold of an agent when trying to call insurance companies. One participant explained how a certain insurance company requires people who call to go through an automated call tree that can take up to two hours until they are finally connected to an agent. At that point, they are placed on hold for extended periods of time, meaning hours can be spent just to get through to a representative from an insurance company. While some participants observed that there were insurance companies that have streamlined this process by allowing certain, if not all billing and insurance related tasks to be completed through their web portal – that may or may not be intuitive and frequently updated – the fact that many health facilities accept a multitude of plans means that one insurance company's streamlined process may not necessarily streamline the claims process for a health facility. The nurses noted that arguing with insurance companies, coupled with turnover (that may or may not be attributable to the billing and insurance related aspect of their work), adds to delays in care provided to patients.

Highly specialized and costly care, as well as insurance companies' assessment of how "at risk" a patient is further delays how long it can take to get prior authorization approved. First, highly specialized care, of which multiple of the participants we spoke to were employed at either the only or one of the very few facilities that offered such care in the state of New Mexico, presented more hurdles in terms of getting care covered by insurance

[4] Starting in 2026, the Centers for Medicare and Medicaid Services (CMS) requires insurance companies to respond within 72 hours for urgent prior authorization requests and seven calendar days for standard requests. Some states already have addressed quicker turnaround as well, such as Vermont.

companies. This means that in order to treat patients, it will always or most of the time require prior authorization, which as mentioned above, can take weeks to months to get authorized. Furthermore, many participants expressed frustration with the recent uptick in peer-to-peer requirements during the prior authorization process which requires clinicians to justify medically necessary care to an insurance company doctor. As mentioned above, communication with insurance companies need to occur during business hours, which prevents clinicians from seeing more patients.

Second, as one participant explained, prior authorization times vary by how insurance companies assess the risk level of patients. They found that often, children and people with comorbidities deemed "at-risk" will get faster approval. However, as this participant explained, these standardized measures that the insurance companies use, such as Body Mass Index (BMI) are not necessarily a good measure for the work they specialize in in understanding how much in need a patient is to be seen. Therefore, while the time that these more "at-risk" groups are able to be seen may be faster, they may not serve all those who need it, highlighting the power that insurance companies have in determining who can be seen when.

Coupled with the fact that these highly specialized facilities can have months-long waitlists – or even waitlists so long that they do not accept any new patients – this presents a serious issue with providing patient care. Some even noted that patients will have to travel out-of-state to receive the care that is needed due to delays, which may be inaccessible for people with lower incomes.

During Patient Encounters

Once patients can be seen, billing and insurance related tasks further limit how much time is spent face-to-face with physicians and other clinicians.

One clinician we spoke with said that they spend around 30 minutes on an average with each patient they see, of which they spend between 15-20 minutes with the patient, and another 10-15 minutes on documentation. One physician who works in emergency medicine explained that they use their non-clinical time for charting (which is also used for billing and insurance related tasks), so that they can see as many patients as possible during clinical hours. They mentioned that therefore, charting and billing and insurance related tasks do not interfere with patient care, but that it does affect their overall workload. This participant noted that they had been warned by other clinicians that this may lead to burnout down the line. However, as many other physicians we spoke with explained, depending on what aspect of the billing and claims process needs to be addressed, it is sometimes impossible to do billing and insurance related work outside of business or clinical hours.

They said that because of this, billing and insurance related tasks do take away from time with patients and overall quality of care. While the clinicians agreed that charting is a necessary and important component of their work – for communication purposes to ensure there is a record of a patient's medical history and the care that was provided – they said that

the requirements for insurance on how charts are written adds an unnecessary burden that feels like busy work that does not lead to improved care.

The difference in charting by the insurance that a patient has was made especially in reference to patients who have Medicaid or Medicare. Participants addressed the especially bureaucratic rule of the Centers for Medicare and Medicaid Services (CMS), the self-attestation requirement, that asks clinicians to attest that what they charted is correct themselves. According to one clinician: “It makes it so much easier to just use charts for communication purposes and not for having to check boxes. It takes a mental strain going through five different steps.”

Another clinician, who has been working for over almost three decades across two different hospitals in the state, observed how much more time-consuming billing and insurance related tasks have become over time. Noting that while in the early to mid-2000s, attending notes required a minimal amount of time, especially over the past decade, the requirements and questions needed to be filled out has grown, adding a significant amount of time. Noting especially the CMS questions that included pain assessments and housing situations, this clinician was questioning the utility of including this information within the context of providing patient care or improving patient outcomes.

Navigating issues of in- and out-network providers can further add excessive time on the already full plates of both clinicians and claims staff. For example, one clinician noted how time intensive it can be to get medication transferred for patients to an in-network pharmacy.

After Patient Encounters

Even after patient encounters are completed, billing, insurance, and claims tasks pose a serious strain on clinicians who are trying to provide patient care.

One notable issue is denials. As we will discuss in greater depth below, denials are claims that have been reviewed and denied by insurance companies. Clinicians are often involved and tasked to help with amendments and appeals to ensure that their health facility gets reimbursed.

Denials do not only happen immediately. According to multiple clinicians we spoke to, insurance companies sometimes deny previously accepted claims. According to the clinicians we spoke to, insurance companies backtrack denying previously accepted claims from 9-12 months ago (one even noting care from as far back as 2023). The process of rectifying this and trying to ensure that these claims get accepted again is draining and time consuming for clinicians, with one noting that there is a lot of “mental jiu jitsu” that happens with trying to remember everything that happened that far back, going through and editing charts again.

Frequently Changing Rules and Updates and Their Impact

Another aspect that adds both time and complexity to the billing, coding, and claims process is that rules, administered by multiple different entities and agencies, frequently change. Medical coding uses the International Codes of Diseases (ICD) (currently, the claims staff we spoke to said that they use the ICD 10, which lags behind what is used around the world, which is ICD 11), and Healthcare Common Procedure Coding System (HCPCS) codes, and the Current Procedural Terminology codes (CPT) to classify performed procedures for billing purposes. Clinicians also spoke about formulary, which is a list of drugs covered by health plans. All the above mentioned undergo frequent changes – according to participants, new ICD codes are released in October, and new versions of CPT codes are released in January. Formulary is updated at least once a year, every July, according to the participants. Amendments may occur for the ICD throughout the year, and major revisions to the ICD only occur about every ten years. CPT codes, as mentioned, may be updated and amended more frequently as well, and there may be new inclusions throughout the year. While as mentioned, formulary is usually changed every July, some insurance plans may update these more frequently with some even having monthly changes. Participants noted that the frequent changes are exhausting and time consuming and complicate providing patient care.

"Billing is not black and white. If you're coding according to the book, it won't work." Similarly, other billing and claims professionals found that the work requires a lot of creativity and adaptivity due to the frequent changes in rules. One biller we spoke to went as far to say, **"if you follow the book, no one gets paid."**

When asked if health facilities offered designated time to learn the new codes, all claims professionals said that they did not. They explained that for the most part, they do use only very specific codes within their facilities but also that they use their own free time to read updated manuals. Participants all agreed that the continuous change means that even once you think you have a specific code and rule figured out, it will likely not be applicable the next time they use it, which requires a lot of investigative skill. Furthermore, even though codes get updated, Electronic Medical Records (EMR) or other computer systems often lag and are not updated, meaning that even when appropriate codes are used to log procedures and care performed, the system does not recognize them, leading to unnecessary delays in getting reimbursed by insurance. Given the continuously changing landscape, the high need for adaptability, willingness to take initiative, and desire to learn changing rules, one hospital worker believed that this may be the cause of high turnover they experience in their facility. What is more, the claims professionals explained simply following these standardized processes is not enough. As one claims professional said, "Billing is not black and white. If you're coding according to the book, it won't work." Similarly, other billing and claims professionals found that the work requires a lot of creativity and adaptivity due to the frequent changes in rules. One biller we spoke to went as far to say, "if you follow the book, no one gets paid." Not only does this point to issues with the frequent changes in codes and rules, but also to the fact that simply following manuals alone is insufficient.

Speaking on formulary, especially the clinicians we spoke to observed that this severely and adversely impacts patient care. They explained that suddenly, a certain prescription, infusion, or treatment is no longer covered by insurance even if the clinicians had observed success of said treatment. This leads to either having to submit prior authorization – which requires a physician to obtain permission from a health care plan to use certain services, treatments, or prescription – to continue care or having to shift the type of care that is provided, both of which can be time intensive and adversely impact patient care. More on the adverse impact of formulary changes on patient care will be addressed below.

Insufficient Infrastructure and Solutions

Almost all claims professionals we spoke to felt that their facilities either did not have sufficient staff or infrastructure to process the current claims load.

The number of claims professionals varied broadly within the respective facilities where respondents were employed and varied irrespective of health facility size. Smaller health facilities had one to two billing and claims professionals while a facility with 50 employees total had seven people working in claims, billing, and coding. A number of hospital claims staff we spoke to said that their respective departments had a small number of claims staff (one noted that their department employs a total of four claims staff within a department of 15) although proportionally speaking, claims staff made up a larger share of their staff than at other facilities within our sample. However, all hospital workers we spoke to across the focus groups did not know how many claims professionals worked in their facilities in total given the large size of their hospitals and the many channels billing and insurance related tasks go through. While each department or division has their own claims staff, the larger health facilities also have claims staff in designated departments that they do not have much insight into. One participant working in a smaller facility we spoke to had two billers specifically for Medicare and relied on outsourcing billing for privately-insured patients. Overall, there was large variation in terms of how many claims-specific staff a health facility employs.

High turnover means that insufficiently trained and familiarized staff slow down and complicate the process. For example, when discussing turnover, one participant observed how on multiple occasions, new staff get trained and then leave shortly thereafter, which leads to the cycle starting all over again, causing major bottlenecks in their system. Other – even non hospital health facility workers – experienced high turnover at their facility.

One participant, explaining that this phenomenon had worsened since the COVID-19 pandemic, explained that it is especially frustrating when they train staff for two weeks who then decide to leave the organization. This same participant attributed this to both the complexity of the work, and the insufficient training claims staff receive in educational settings that is not reflective of the actual work performed. This participant, who is now enrolled in a training program but had been working in billing for many years, explained how dated the coding training was and that there was no formal teaching on what to do when claims are denied. According to this and many other participants, handling denials is a large

share of their day-to-day duty. The fact that a formal education program does not offer up-to-date training or includes information on what to do for duties that are an essential portion of a claims professionals' job is concerning. Participants noted that this disconnect between training and actual work performed may mean that potential future billers and coders may receive training and then find themselves not adequately trained or prepared for the career they chose to embark on, leading them to leave and choose different career paths. All of this combined leads to large turnover, and subsequently insufficient staff and infrastructure at health facilities to successfully process claims loads.

Another factor that is both an infrastructural and staffing-related challenge to processing claims loads, and adversely impacts clinicians' workflow, is the possibility of a disconnect between clinicians and staff. Especially some of the hospital workers we spoke to found their facilities to be convoluted, where there were many workers and departments working on different parts of the billing and insurance related process.

While this was not a persistent theme across focus groups and different health facilities, this disconnect may be more observable in larger health facilities, such as larger hospitals. In particular, while the clinicians we spoke to all agreed that charting continues to be an important part of the work that they conduct – because it keeps track of patient diagnoses, treatment provided, and other important factors – they noted that the way they have to do their charting is heavily influenced by billing and insurance related issues. One clinician said that in their hospital, billers and coders tend to interpret charts more conservatively. They elaborated giving the example of how, at their health facility, unless they spell out in minute detail what their diagnosis means, the severity of diagnoses gets downgraded, which tends to be more favorable for insurance companies and does not reflect the actual care and cost of care provided. According to this respondent, this adds an unnecessary layer of work. Similarly, other participants also believed that some of these issues may be attributable to the fact that claims staff are usually not medically trained. While there is a back-and-forth dialogue that happens between claims personnel and clinicians, the lack of medical knowledge further adds unnecessary time that is taken away from patient care.

One notable exception in our sample was one claims professional who explained that billing, coding, and claims had been streamlined efficiently within their place of work. Within this particular health facility, staff had designated roles within the revenue cycle, with specific staff working on coding, handling rejections and denials, prior authorizations, and patient collections, and a small number of staff cross-trained and able to fill in if there were higher loads in a particular part of the process. Within this facility, this process worked well, although across participants, this facility seemed to be more of an outlier than the norm and it is unclear whether this structure could be implemented equally well in different facilities that may be larger.

To address the issues of insufficient infrastructure and staff to handle patient billing loads, multiple participants we spoke to, all working in different health facilities in different parts of the state, noted that their facilities had implemented solutions to streamlining billing.[5] Two

[5] The topic of streamlining billing is a constant conversation that management has with staff according to one focus group.

that stood out the most across focus groups were Artificial Intelligence (AI) and outsourcing billing.

Artificial Intelligence

A number of participants explained that their facility is currently or is in the process of shifting to using AI, with variation on how it is being used currently. Those who have had experience noted that while AI is not able to replace claims staff or eliminate the need for clinicians to spend any time on billing and insurance related tasks. However, health facilities that are using AI appear to have streamlined some processes. For example, in one of the health facilities where a participant is currently working, AI is used to flag any errors in claims submissions. This participant found that this has so far been successful and reduced the number of rejections dramatically within their facility.

Similarly, other participants stated that the large hospital where they are currently working is in the process of implementing AI, so they could not speak to how effective or efficient this has been for claims. One of these participants has been on an internal waitlist for four weeks to receive mandatory training before being allowed to use AI during their clinical hours. Another clinician who works at a hospital explained that AI has been integrated in their health system software over the past year and how much this has simplified the note-taking process. At this facility, clinicians use ambient listening, which records health encounters and automatically creates notes and recognizes the complexity of them.

When asked about the accuracy of these automatically generated notes, this clinician said that the automated notes and the complexity determination have been more accurate than when people have done them. Furthermore, they added that ambient listening adapts to the speaking style of clinicians, meaning that it adapts, learns, and improves. In terms of improving the work-life of clinicians, this participant explained that using AI has improved morale and productivity among them and how prior to adopting AI technologies, they were often overburdened with both documentation and fulfilling requirements of accreditation agencies.

However, while the note taking and billing components of their work were eliminated, prior authorization and denials are still needed to be done by themselves. Another clinician also raised ethical concerns that may arise due to utilizing or over-relying on AI. This includes the delivery of quality care, especially the concern that even the choices of medications, for example, may be determined by AI in the future that relies on insurance-based formulary, the question of where the metadata is stored even with encryption, and finally, who will be held liable for poor decisions as more AI is used.

Outsourcing

Another measure some facilities used to address the issue of insufficient infrastructure is outsourcing claims. The degree of how much of the claims process was outsourced depended on the facility, ranging from outsourcing certain aspects of the process, outsourcing billing and claims for private insurance only, to outsourcing the entire billing, coding, and claims

process. However, even with facilities that completely outsourced claims, there were certain components that still needed to be completed within the respective health facilities to ensure that the outsourced companies could process claims. Multiple participants that had experience with outsourcing either at their current or a previous employer in the state raised a number of concerns and criticisms that arise by relying on outsourcing.

First, multiple participants found that outsourced companies have "no heart in the [health facility that has hired an external company to process claims] so they don't fight for the money." One worker from a health facility said that eventually, their facility parted with an external company after the workers addressed the issue with leadership, and even then, it took leadership six months to end the contract.

> "We don't care [if you guys get reimbursed.]. We get paid regardless."

Second, another issue with outsourcing was that out-of-state companies that claims were outsourced to did not know or understand New Mexico-specific rules regarding billing, further leading to unrecouped insurance payments. This participant said that they had even explicitly been told by this out-of-state company that, "We don't care [if you guys get reimbursed.]. We get paid regardless." Another participant went as far as to say that outsourcing had been a factor in the closure of a health facility where they were employed, due to a lack of the outsourced company's understanding of billing for the services that health facility provided. While this facility moved on to a separate billing company, the second company proceeded to process claims in a questionable and borderline illegal-manner, which has led to litigious action being taken by their facility against the outsourced company.

Third, outsourcing billing can be an issue because companies can be unresponsive, which can affect whether and how claims are processed and posted, and how and if health facilities ultimately get paid by insurance companies.

Finally, speaking on the impact outsourcing has on patients, one participant noted that it has become incredibly difficult to get an itemized bill for the services they receive and are ultimately billed. Relating this to another point of unpaid bills that will be addressed later in this report, depending on the health facility patients go to, they may not have a lot of time to pay their bills before it gets sent to collections and subsequently turn into bad debt. The difficulty of accessing an itemized bill and catching any potential errors that may lead to overcharging patients, is a serious concern especially for patients that are low-income.

Ultimately, while outsourcing may be used for a myriad of reasons, including to cut expenditure on claims and to streamline the process, according to our participants, it can actually lead to revenue loss and adversely impact patients.

The Impact of Specialized Care on Billing and Insurance Related Tasks

One common theme across participants was how specialized care tends to be more time consuming for billing and insurance related tasks. This is because not only does specialized care usually require prior authorization before any care can be provided that needs to be covered by insurance, but also because justifying payments for specialized care is more time intensive. Participants attributed this in large part because this type of care tends to be pricier and more time intensive in terms of providing care.

For example, one participant noted that in their highly specialized clinic – one that is its only kind within our state and treats patients not only from within the entirety of New Mexico but even neighboring states – patients usually spend about half a day for tests, treatments, infusions, and other types of care. This participant explained that a part of the care they provide includes necessary standard testing for patients in order for them to receive the specialized treatment that they are seeking out at this facility. However, this presents an insurance issue for patients who are coming in from out-of-network, whose insurance companies usually flag that this type of standard testing is available at health facilities that are in-network. To avoid patients having to go to multiple different facilities just so that they can ultimately receive the specialized care that they need (and were on months-long waitlists for), requires health facilities to spend extensive time to justify payments and secure prior authorizations.

As will be discussed more below, this was one of the many times participants expressed frustrations about the impact that insurance companies have on providing care for patients. Multiple participants explained that it often feels as though the default answer of insurance companies is to deny claims, meaning that it feels that the process of justifying why patients need care is not only unnecessarily time intensive but also met with a lot of resistance and arguments.

As mentioned in the section on how much time is spent, securing prior authorization in itself can be a time-consuming process that can delay access to healthcare for patients by months. Since most, if not all, highly specialized care requires prior authorization that vary in approval times depending on how "at risk" an insurance company deems a patient by measures that may or may not be reflective of urgency of care needed, coupled with the fact that highly specialized health care, especially in the state of New Mexico, is already difficult to access due to shortages and subsequent long waitlists, is a critical barrier to patient care. As one specialist we spoke to noted, the strenuous requirements of getting prior authorizations for nearly everything and the subsequent inability to provide care creates provider-drain. Another participant elaborated that these frustrations have led many psychiatrists in particular to move to cash practices that no longer accept insurance, although as another participant not working in mental or behavioral health who owns a private practice explained, they had also moved away from accepting insurance for the very same reasons.

Denials and Rejections

One participant, noting their frustration with appealing denials, said: **"so much time is spent on arguing back and forth. Patients are just trying to get care."**

Rejections are claims that are returned before they could be processed due to errors and denials are claims that were evaluated and denied based on a patient's policy. Across the focus groups we conducted, denials and rejections were common, time consuming, and costly, and most participants had experience working with and on rejections and/or denials. While participants agreed that certain insurance companies were worse at denying coverage than others, there was little consistency across health facilities as to which insurance company these are. What participants consistently did agree on, however, is that it feels as though insurance companies, by default, deny claims. One participant, noting their frustration with appealing denials, said: "so much time is spent on arguing back and forth. Patients are just trying to get care."

Multiple participants stated that the frequent changes and updates in codes, and delays in updating EMRs or other software sometimes leads to rejections in particular. This shows that the frequent changes in rules, and delays in adequately and appropriately adjusting to them adds additional time and work to claims staff that are already overworked.

Another participant from a different health facility mentioned that one insurance company denied between 40-50% of claims submitted including for flu shots. This insurance company did not have agents who served their location, making it more difficult to dispute claims, which consequently led to this health facility terminating their contract with this insurance company.

One clinician we spoke to noticed that they have had issues with automated denials they received for patients over 70 years old who were prescribed medication with diphenhydramine (the active ingredient of Benadryl) – with insurance companies justifying the denial with a statement on how it increased the risk of dementia – and instead recommended clinicians to use a Benzodiazepines instead, which according to this clinician, are much more dangerous and addictive.

When it comes to how to address rejections or dispute claims, similarly, it depends on insurance companies. As mentioned in a previous section, some insurance companies have simplified this process, allowing claims staff to address rejections and claims on their online portals, which significantly simplifies the process. However, others require a phone call, and as mentioned, with one company, this means that in order to get ahold of an agent, claims staff have to navigate an automated call tree for about two hours before getting placed on an extended hold.

A few participants we spoke to either are currently or used to work in positions where their primary responsibility involved handling rejections and denials. According to these participants, their employer usually requires quotas that are either dollar-based, meaning that

they had to reach a set dollar amount while processing rejections and denials in a given week, or time-based, meaning that rejections and denials had to be processed within a given timeframe. One of the participants had calculated the cost of this process, explaining that it costs the health facilities $20 to submit an appeal, meaning that if an insurance-based reimbursement totals $100, if appeals have to be submitted, the actual recuperated cost is only $80. Adding to the costliness of denials and rejections, and the tight margins some health facilities operate on, one worker from a rural health facility we spoke to had received a facility-wide note from their management when seven claims were denied within one month because that exceeded their budgetary allocations for denials.

Rural Areas of the State Face Enhanced Challenges

Due to the regional variation of the health facilities whose employees participated in our focus groups, we were able to identify some location and rural specific challenges related to claims and billing in general that adversely impacts patients and patient care.

First, especially in rurally-located facilities, insurance covered options were limited within specific towns and/or counties. For example, one participant said that due to what laboratories are in- or out-of-network for patients, patients would have to travel out of their county all the way to Albuquerque if they wanted to get testing done that is covered by their insurance companies.

One participant gave the example of a simple strep test that a patient ended up paying out of pocket for due to the significant cost of travel to the closest in-network laboratory located in Albuquerque. The respondent noted that the cost of travel was not worth the cost covered by insurance. Similarly, another rurally located health facility worker explained the difficulty for veterans to receive care in their county, because their local clinic does not have a partnership with Veteran Affairs (it closed in their county). This leads to veterans living in this area to have to travel long distances to receive insurance-covered care. Another participant located in another town said that their town's primary pharmacy does not accept insurance from one of the major insurance companies meaning that patients will either have to change Managed Care Organizations (MCOs) to more easily get their prescriptions filled and covered at said pharmacy or travel out of town to a pharmacy that takes their MCO.

Relevantly, this particular health facility, according to the participant, has recently had a number of physicians stop accepting another insurance company (not the same insurance company that the pharmacy does not accept). This illustrates the many hurdles patients face when choosing MCOs that they may not be familiar with in advance, that present challenges in accessing insurance-covered care within their own communities. Furthermore, as explained above, transferring medication from an out-of-network to an in-network pharmacy can be an incredibly time intensive process for clinicians as well, which ultimately will impact patient care due to them spending more time on billing and insurance related tasks rather than having face time with their patients.

Second, another location specific challenge that affects the quality and cost of care in especially rural communities is mis- or inadequate information that patients are educated on

about Medicare. One worker from a health facility that serves a lot of tribal community members said that many tribal members have traditional Medicare and do not choose Managed Care Organizations. However, according to this participant, some health facilities (although this was not the case for their facility) make patients on traditional Medicare choose an MCO without educating or informing them on which will serve their needs best. As other participants noted, switches in MCOs for Medicare patients can lead to higher copays and coverage changes can be particularly impactful for people living on a fixed and incredibly limited income. While the common $5 copay may not be perceived as much money to pay for care or medications, as participants explained, for many elderly and impoverished New Mexicans that have comorbidities, this amount adds up fast and becomes unaffordable in the process.

Almost all of the claims and billing workers that we spoke to spend a lot of time educating patients on their insurance plans, what it does and does not cover, and how to receive less costly care. It is important to consider that this is one of the many work-related responsibilities expected of claims professionals that tend to have a large turnover.

Third, rural health facilities already struggle, and the issue with insurance-related billing and claims contribute to closures and decreasing access to care. As one participant working at a rural health facility said, "Rural medicine is different – it is different in terms of billing, staffing, recruiting. [Citing when this participant was working in a more urban setting in the past] Working in [name of larger city] was easy. Here [citing their rural town] – not so much." This participant noted that issues with insurance companies are just the tip of the iceberg of contributing factors to closures of smaller private practices in rural settings.

"Rural medicine is different – it is different in terms of billing, staffing, recruiting…Working in [name of larger city] was easy. Here [citing their rural town] – not so much."

Other issues, such as the fact that this participant's community does not even have a blood bank, is another one of the myriad of challenges that rural health facilities face. Furthermore, as will be discussed more in the next section, these rural health facilities serve more impoverished and older populations, and consequently more patients who are on Medicaid and Medicare. Due to the low reimbursement rates of both Medicaid and Medicare (meaning that the payment received from either usually does not cover the full requested amount) – and the fact that many patients receiving care are unable to cover the expense of the care they receive – makes it increasingly difficult if not impossible for these health facilities to continue serving rural communities.

Differences Between Public and Private Insurance

Overall, participants were frustrated with insurance companies, and specifically with the many processes and rules that prevent or obstruct patient care. For example, in reference to the many tight timelines put in place by insurance companies on health facilities, one participant

said, the “medical side has to adhere by a lot of rules that the insurance companies don’t.” As one clinician mentioned, “big pharma isn’t the enemy anymore – insurance companies are.” Many attributed this to the fact that “insurance companies are dictating all of the billing. It’s not coming from doctors or clinics,” and because insurance companies are making backdoor deals with pharmacies and pharmaceutical companies to cut down on spending and maximize profits, rather than taking patient care and wellbeing seriously.

Although we asked participants about which insurance companies were better at making the billing and claims process easier, there was no clear consensus when it came to private insurances and it seemed health facility-dependent. For example, processing claims, receiving prior authorization, and other billing and insurance related tasks tend to be easier to do at facilities that have integrated insurance and healthcare delivery. However, outside of these facilities, and when patients receive care out-of-network, billing and insurance related tasks become more complex and time consuming.

Participants did observe some differences between private and public insurances however, although there similarly was variation. Almost all of the participants we spoke to have had extensive experience with Medicaid and Medicare, which in New Mexico, is to be expected. Some found Medicaid and Medicare to be easier to navigate or relatively simple in terms of billing, and providing care. As one participant, who works at a facility that treats patients with substance use disorder, explained, Medicaid offers significantly better support than private insurance companies do. This participant noted that for the services they provide, private insurance companies usually only offer 30 days of care, which according to them, is insufficient in treating substance use disorders which are life-long conditions.

However, many participants we spoke to expressed a lot of frustration with Medicaid and Medicare. The clinicians we spoke to, as explained in an earlier section, found that the CMS requirements are unnecessarily time consuming and burdensome on clinicians and importantly do not improve patient care. This includes the self-attestation requirement, where clinicians have to attest that what they charted is true each time they enter records for their patients, the long list of questions including the housing situation of patients (such as whether they live in a two- or three-story building), and the requirement to create a treatment plan. As one behavioral health clinician we spoke to elaborated, treatment plans were onerous and included setting goals with patients that are obvious, which within their context includes goals such as “treating depression.” As this clinician explained, the reason why these patients seek help is clear and the treatment plan is just unnecessary and burdensome paperwork that does not, nor has it ever, improved patient care.

Another important issue with both Medicaid and Medicare that was brought up across participants were the low reimbursement rates, meaning that oftentimes, they only reimburse about 25% of the billing amount. There was some variation across subspecialties in terms of how much gets reimbursed through Medicaid and Medicare, but the issue of low reimbursement was relatively consistent. One participant, speaking about a costly medication that is used at their facility noted that the reimbursement rates are so low from Medicaid, that their facility loses money every time they prescribe said medication.

Despite the frustration with Medicaid and the CMS requirements, participants did not necessarily prefer private insurance, listing multiple issues such as the requirement to receive prior authorization, increasing numbers of peer-to-peer requirements during this process, and the frequently changing formulary. As mentioned above, the backdoor deals insurance companies make with pharmaceutical companies, and limitations and restrictions of medications, laboratories, and treatments present a serious barrier to providing quality, evidence-based health care.

The Issue with Unpaid Debt

We also asked participants about what happens with unpaid debt, specifically bills that patients are unable to pay. Similarly, there was large variation that was both location and health facility-size dependent. The participants employed at large hospitals noted that their hospitals have charity funds or hospital-specific health care solutions that can assist patients who cannot cover their medical expenses themselves. However, especially the participants employed at smaller, rurally-located, and low-income patient serving facilities mentioned that unpaid bills usually get sent to collections that subsequently turn into bad debt for patients.

Notably, one participant not employed at a hospital explained that their facility has made it a point to not send patients' unpaid debt to what they described as "collections-collections," meaning that it does not turn into bad debt and their facility usually covers the cost of this unpaid bill. At other facilities, however, unpaid bills are sent to collections and turned into bad debt that often still does not get paid because patients simply cannot afford it. Unpaid bills are usually sent to collections between 90-120 days of non-payment, but many of these facilities do offer some support including a 30% reduction and/or a payment plan. However, as mentioned, many patients are still unable to pay meaning that not only does that mean that the facilities will bear the unrecouped cost, but patients are burdened with bad debt. Speaking on the issue of how little patients can afford, one participant gave the example of a patient who sent a $10 bill to their health facility to cover their expenses – which of course, was not nearly enough to cover the actual cost of care they received – because that was all that they could afford.

The Impact on Health Facility Cash Flow

The extensive time that goes into billing and insurance related tasks leads to significant costs. As an example of the consequences of this rise in costs, one private independent practitioner we spoke with no longer accepts insurance. This participant said that it was no longer financially viable to engage with and argue back and forth with insurance companies and not be able to provide the care patients need. This practitioner stated that four years ago their facility stopped taking insurance as there was too much paperwork and too many denials in which their facility was not getting paid. They explained how insurance companies would go back and retrospectively deny a service and take money back by garnishing present payments, which requires bringing in more staff and multiple providers to generate revenue

which limits the abilities of doctors who want to practice independently. A similar observation was made by participants employed by a rurally-based practice, who noted private practices have become unsustainable in rural New Mexico for the very same reason.

A large contributing factor to this, as mentioned in the section on the difference between public and private insurance, is that there is a disconnect between services provided and money recouped from insurance. While that section especially highlighted this issue in terms of Medicaid and Medicare, not getting 100% of the requested amount is an issue across public and private insurance. One hospital clinician explained that sometimes, they bill insurance for $40,000 worth of services and only get reimbursed for $10,000. They explained that the remainder of the cost falls on the hospital that leads to loss in revenue. Adding on to this conversation, another clinician from a hospital found it frustrating that the hospital is losing so much money even though many of their providers have months-long wait lists. Given that compared to the national average, a much larger share of New Mexico residents are insured through Medicaid and Medicare, the trend in our discussions that these two forms of insurance in particular reimburse at lower rates, this makes it unsustainable for smaller practices and difficult even for larger facilities to operate and stay afloat. This ultimately creates barriers to entry for practitioners who want to go become private practitioners.

The Impact of Medical Billing on Patient Care

> "Clinical decision making is driven by insurance formulary, not individualized patient care. I always jokingly tell residents: **'In medical school, we learn evidence-based medicine. In residency, we learn systems- and insurance-based medicine and often, those are two very different things.'**"

The challenges with medical billing negatively impacts the quality of care for patients. While providers try their best to provide quality care to their patients, issues such as changing formulary have adverse impacts on patient care. As multiple participants stated, clinicians have to submit prior authorization to keep patients on medication or treatments that they were on before the change in formulary. Some even explained that they first had to prove that the new medication that is covered under the new formulary is having adverse effects on patients *first* before being able to successfully get prior authorization approved to give patients the medication they were receiving before formulary changes no longer covered said medication. As one clinician stated: "Clinical decision making is driven by insurance formulary, not individualized patient care. I always jokingly tell residents: 'In medical school, we learn evidence-based medicine. In residency, we learn systems- and insurance-based medicine and often, those are two very different things.'"

Relatedly, as one clinician emphasized, there is a sense of hostility between insurance companies and accreditation agencies against providers that drives many of these decisions as well. As this participant explained, providers are often viewed as wasteful, which leads to frustration of providers who are trying to provide evidence-based and personalized care to the patients they treat.

Another important consideration that was discussed with some participants is the issue of private equity-controlled hospitals and health facilities. It is noteworthy here as well that we had had a difficult time recruiting participants from multiple private equity controlled hospitals, with one of our recruiters being told when they tried to recruit participants from multiple facilities, that they are not allowed to participate in research. As one clinician, who works at a non-profit hospital said, "If [my hospital] got bought out by private equity, I'd leave," noting the extensive evidence in the negative impact that private equity controlled facilities have on patient care and outcomes and clinical and non-clinical staff.[6] As another participant explained, "I've always felt like, [...] you're called into healthcare for a reason, and if you're doing it for money, you're in it for the wrong reasons.."

The issue of how private equity control over health facilities impacts patients, clinicians, and administrative staff is particularly important to consider in the state of New Mexico, which has the largest proportional share (36.2% of all hospitals)[7] of private equity controlled hospitals in the country. Furthermore, nation-wide, 22.6% of psychiatric hospitals are private equity controlled as well,[8] which given that New Mexico, as of 2024, ranks 30th in terms of prevalence of mental illness and access to care, is another troubling observation.

If [my hospital] got bought out by private equity, I'd leave..."

Recommendations

The findings from our focus group discussions motivate a handful of recommendations we believe warrant consideration from the state. These include both short-term action items as well as more long-term system level reform considerations that we believe will improve patient care and health outcomes. One consistent issue that many clinicians and claims staff spoke about was prior authorization. To ensure a clinicians can spend more time with their patients, the prior authorization process needs to be streamlined and simplified. The prevalence of peer-to-peer requirements overburden clinicians. Clinicians we heard from consistently noted that their primary goal and most important tasks is to treat patients using evidence-based care. However, the need to engage in these billing and insurance related tasks takes valuable time away from actual interaction with patients. There have been some noteworthy advancements in this aera. In fact, CNBC recently published an article that mentions multiple insurance companies that are reducing the number of prior authorizations and will speed up the process in the coming years.[9]

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[6] Morgenson, G. (2021, December 20). "Get That Money!" dermatologist says patient care suffered after private equity–backed firm bought her practice. NBC News. Retrieved from https://www.nbcnews.com/health/health-care/get-money-dermatologist-says-patient-care-suffered-private-equity-back-rcna9152

[7] Private Equity Stakeholder Project (2025, April). *PESP has created the Private Equity Hospital Tracker (April 2025).* Private Equity Stakeholder Project. Retrieved from https://pestakeholder.org/private-equity-hospital-tracker/

[8] Ibid

[9] Constantino, A. K. (2025, June 23). *Prior authorizations: U.S. insurers to change approval process.* CNBC. Retrieved from https://www.cnbc.com/2025/06/23/prior-authorizations-us-insurers-to-change-approval-process.html

Other requirements such as self-attestation, asking for a treatment plan, and other administrative tasks associated with billing need to be scaled back or simplified. This issue seemed to be primarily focused on CMS requirements, according to the participants. This appears to be a challenge that has emerged recently, as the more experienced clinicians we spoke with described that many of these requirements are a more recent phenomenon that they did not have to address 10-20 years ago. The current amount of what many described as "unnecessary" or "checking the box" type of paperwork add excessive time to physicians and clinicians broadly who want to focus on seeing patients. It is important to note that the rise of these tasks among clinicians was noted as adding to their stress levels.

It is clear from our research with healthcare professionals that the stress and often lack of training associated with medical billing leads to high turnover within this specialized area of the healthcare system. Greater experience within the system leads to a more effective workforce according to our discussions, so exploring paths to increase retention among medical billing professionals would provide positive outcomes for patients. Training programs for this area of the workforce should include internships and other on-the-job training opportunities to ensure that trainees had a good understanding of what billing and claims work entails.

We conclude with the suggestion to explore system level reforms to the state's medical billing system. The discussions we had with healthcare professionals suggest that the system is in need of significant revision that may not be possible without considering moving to another model. A number of options are available for deeper exploration. Our team is most knowledgeable about the New Mexico Health Security Plan, a program that some experts believe would offer comprehensive health care coverage to New Mexico residents and control costs. Our findings show that despite the time intensive process of completing billing and insurance related tasks, much of the cost is not actually recouped through insurance companies. Many (although not all) of the clinicians and claims processing staff we spoke to explained that the issue of cash flow would often be brought up by management. Streamlining the revenue cycle will not only make physicians more accessible to New Mexicans by cutting wait times and lists, but will also make healthcare more accessible both financially.

Next Steps

The data strongly suggests that that the current medical billing system in New Mexico is in need of reform, as members of the workforce most familiar with the system suggest that challenges in the system are an impediment to efficient, evidence-based care. This unfortunately negatively impacts the care patients receive and clinicians' quality of life. This report is a first step to a greater understanding of how billing and insurance related issues play out in the state of New Mexico, and we propose to expand on this research in the following ways:

1. **Collecting survey/focus group data among privately and publicly insured patients**

   Many participants in the focus groups and interviews found that patient care has been adversely impacted by the revenue cycle. Much of this content is incredibly difficult to understand for people seeking health care who do not have a deeper understanding of health care and insurance. This report focused on the perspectives of healthcare professionals could be enhanced by a survey of consumers to capture how billing and insurance related issues impact patients. We propose collecting a state-wide survey with patients who are insured both privately and publicly to address this question as well as gather data on the attitudes of consumers toward interventions that could be implemented by the state to address challenges raised in our research. The survey could be augmented by focus groups of specific sub-groups of the population that may emerge as uniquely impacted by the complexities of the billing system.

2. **More comprehensive research on implementation of alternative models**

   Through the completion of this report our team has become familiar with several experts, including several under contract with the Legislative Council Service, who have experience implementing alternative modeling in other states and countries. Our team is interested in coordinating broader research on solutions to the cost drivers in the system (global budgets, standardized health professional payment systems, inter-operational IT systems, etc.) through partnerships with some of these researchers.

3. Collect more data of both billing and claims professionals and clinicians practicing in rural New Mexico

Authors and Acknowledgements

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Appendix

Focus Group Script of Clinical Health Professionals in New Mexico

Focus Group/Interview Script for Health Professionals

Thank you everyone for joining us here today. My name is [Name], and I will be moderating our small group discussions today. We will be talking about issues related to billing across the medical system in the state.
Before we begin, I would like to read to you and show you a text asking for your consent to participate in this study. I will explain what this focus group will be about and about your rights.

[Insert Consent Form]

Great, if you feel comfortable continuing, let's get started. Before we begin, I want to establish some ground rules.

- There are no right or wrong answers, your honest opinions and sharing of your experience is what is most important.
- Different opinions are welcome, I want to hear all points of view.
- I want to hear from everyone but only one person at a time should speak.
- Please speak clearly and loudly so that we can all hear you.
- Please make sure your cell phones are silent.
- You will remain anonymous; we only share overall findings in a report for researchers. We ask you to keep the conversations and information you hear in this focus group within the group.
- I will be taking notes and recording this session so that I can accurately capture your thoughts and feelings, but everything you share is never attributed to any person in any manner.

Before we get started, let's go around the room and introduce ourselves. Tell us your first name, where you work and how long you have worked in the medical field.
I'll start, my name is [Moderator introduces him or herself]

Today we are going to focus on medical billing. Our goal is to learn more about how much staffing time is invested in dealing with medical billing issues, including time spent working with patients or their families to sort out issues with their medical bills.

1. We understand that while your main line of work is not centered on medical billing, you will likely have spent at least some of your working time with billing and insurance related tasks.

1.1. Can you give me a rough sense of how much time you spend with billing and insurance related tasks in an average week?
1.2. How much of that time do you think is specifically spent on justifying payments for specific services?
1.3. Has that time increased or decreased over time for you in your health facility?
1.4. Are there any specific types or services that generate more time to address than others?
1.5. Have you received any training in billing and insurance related tasks, or did you learn these skills on the job? What kind of support do you receive from your place of employment to complete billing and insurance related work?
1.6. If you have worked at a different hospital or medical organization in the past, can you describe whether your workload in terms of billing and insurance related tasks looked different in your past places of work? Were these different health facilities located in New Mexico?
1.7. Do you think that time required on these payment accountability tasks impacts staff turnover?

2. We want to get a better sense of how navigating medical billing affects your work.
   2.1. How does having to navigate billing and insurance related tasks impact your primary responsibilities of patient care? Do you feel that billing and insurance related tasks interfere with your work?
   2.2. If a service you provide is not authorized by a patient's plan, are you involved in an appeals process or is that deferred to someone else?
   2.3. How does management address staff concerns about billing and denials?

3. I would now like to get a general sense of your perceptions of working on billing and insurance related tasks.
   3.1. Given our discussion, do you have any additional thoughts you want to share about the impact that billing tasks have on health professionals and their ability to provide patient care?

Thank you so much for your time. Before we conclude this discussion, is there anything else you would like to share about medical billing issues that we have not asked you? Remember our goal is to help inform the state on potential interventions to make billing easier for you and patients across the state.

Focus Groups Script of Medical Claims Processing Staff in New Mexico

Focus Group/Interview Script

Thank you everyone for joining us here today. My name is [Name], and I will be moderating our small group discussions today. We will be talking about issues related to billing across the medical system in the state.

Before we begin, I would like to read to you and show you a text asking for your consent to participate in this study. I will explain what this focus group will be about and about your rights.

[Insert Consent Form]

Great, if you feel comfortable continuing, let's get started. Before we begin, I want to establish some ground rules.

- There are no right or wrong answers, your honest opinions and sharing of your experience is what is most important.
- Different opinions are welcome, I want to hear all points of view.
- I want to hear from everyone but only one person at a time should speak.
- Please speak clearly and loudly so that we can all hear you.
- Please make sure your cell phones are silent.
- You will remain anonymous; we only share overall findings in a report for researchers. We ask you to keep the conversations and information you hear in this focus group within the group.
- I will be taking notes and recording this session so that I can accurately capture your thoughts and feelings, but everything you share is never attributed to any person in any manner.

Before we get started, let's go around the room and introduce ourselves. Tell us your first name, where you work and how long you have worked in the medical field.
I'll start, my name is [Moderator introduces him or herself]

Today we are going to focus on medical billing. Our goal is to learn more about how much staffing time is invested in dealing with medical billing issues, including time spent working with patients or their families to sort out issues with their medical bills.

1. Why did you get into medical billing? [prompt to see: are these potential recruits to work in healthcare field in general]
2. How many staff in your health facility do anything related to processing billing and payments?
    2.1. Do you feel that there is sufficient staff and infrastructure to deal with your facility's current claims processing load?
    2.2. Do you know if staffing dedicated to billing processing increased or decreased over time in your health facility? How have any changes in staffing impacted your own workload?
    2.3. Do you know or can you estimate the number of staff focused on processing billing payments to public and private insurance plans or to the uninsured?

3. How many insurance plans do you deal with on a regular basis? Are there a variety of plans from different public or private companies? Are there different requirements for each plan offered by an insurance company so you have to fill out different forms depending on the insurance plan?
    3.1. How much time does it take for the insurance company to respond? Do response times vary depending on the insurer?

3.2. Are there any specific challenges you face that are different between public and private insurance companies?

4. What is the list of things you have to fill out to justify payments?
   4.1. How much time does that take?
   4.2. Are there any specific types or services that generate more time to address than others?

5. What is the estimated percentage of claims you process that end up getting disputed?
   5.1. Is there a process in place at your health facility when the insurance company rejects a claim?
   5.2. Are you informed about denials? Can you fix the problem or does someone else have to do this?
   5.3. How much time and effort go into disputing payments with insurers?

6. To what extent are you involved in collecting payments from patients?
   6.1. What happens to patients if they fail to make payments?
   6.2. Does your office have any protocols in place to help determine when a patient's unpaid debt is turned over to collection agencies?

7. Do you know what percentage of your health facility's budget is dedicated to billing and insurance related tasks?

8. Are there any specific billing and insurance related challenges that you believe are related to working in a more urban or rural area?

9. Does the specialized work of processing claims have an impact on staff turnover? Why?

10. Has management discussed with you and other billing staff alternate ideas of streamlining billing?

Thank you so much for your time. Before we conclude this discussion, is there anything else you would like to share about medical billing issues that we have not asked you? Remember our goal is to help inform the state on potential interventions to make billing easier for you and patients across the state.