LFC Requestor: Eric Chenier

2024 LEGISLATIVE SESSION
AGENCY BILL ANALYSIS

Section I: General

Chamber: Senate

Category: Bill

Number: 17

Type: Introduced

Date (of **THIS** analysis)**:** January 29, 2024

Sponsor(s): Elizabeth "Liz" Stefanics and Doreen Y. Gallegos and Michael Padilla and Jason C. Harper and Martin Hickey

Short Title: Health Care Delivery and Access Act

Reviewing Agency: Agency 665 - Department of Health

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Section II: Fiscal Impact

APPROPRIATION (dollars in thousands)

Appropriation Contained		Recurring or Nonrecurring	Fund Affected
FY 24	**FY 25**		
$0	$0	NA	NA

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Nonrecurring	Fund Affected
FY 24	**FY 25**	**FY 26**		
$0	$0	$0	NA	NA

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY 24	FY 25	FY 26	3 Year Total Cost	Recurring or Non-recurring	Fund Affected
Total	$0	$0	$0	$0	NA	NA

Section III: Relationship to other legislation

Duplicates: None

Conflicts with: None

Companion to: None

Relates to: None

Duplicates/Relates to an Appropriation in the General Appropriation Act: None

Section IV: Narrative

1. BILL SUMMARY

a) Synopsis

Senate Bill 17 (SB 17) would enact the Health Care Delivery and Access Act, creating the Health Care Delivery and Access Medicaid-Directed Payment Program and the Health Care Delivery and Access Fund. It would impose assessments on certain hospitals to be used for additional reimbursement to hospitals with the goal of improving and increasing access to hear care services in the state.

Is this an amendment or substitution? ☐ Yes ☒ No

Is there an emergency clause? ☐ Yes ☒ No

b) Significant Issues

Rural hospitals and health systems make up about 35% of all hospitals across the country and include critical access hospitals (no more than 25 acute care beds and more than 35 miles from the nearest hospital), frontier hospitals (six or fewer residents per square mile) and sole community hospitals (hospitals for Medicare beneficiaries in isolated communities), among other Medicare designations. In New Mexico, there are currently thirteen (13) hospitals that are licensed with fewer than 30 beds. (nmhealth.org/publication/view/report/5676/ page F-21).

Rural hospitals are major economic drivers, supporting one in every 12 rural jobs in the U.S. and contributing $220 billion in economic activity in their communities in 2020. *(American Hospital Association: Hospital Closures Threaten Patient Access to Care as Hospitals Face a Range of Rising Pressures:* https://www.aha.org/press-releases/2022-09-08-new-aha-report-finds-rural-hospital-closures-threaten-patient-access-care). A variety of factors have contributed to closures, such as financial pressures, challenging patient demographics and workforce shortages. Communities served by critical access hospitals (CAHs) and other rural hospitals tend to have older, sicker, and poorer populations with access to fewer health care professionals. Rural hospitals make up about 35% of all hospitals in the U.S. Nearly half of rural hospitals have 25 or fewer beds, with just 16% having more than 100 beds.

The Centers for Medicare & Medicaid Services (CMS) announced a new primary care model – the Making Care Primary (MCP) Model – that will be tested under the Center for Medicare and Medicaid Innovation in eight states. Access to high-quality primary care is associated with better health outcomes and equity for people and communities. MCP is an important step in strengthening the primary care infrastructure in the country, especially for safety net and smaller or independent primary care organizations. CMS is currently testing this advanced primary care model in Colorado, Massachusetts, Minnesota, New Jersey, New Mexico, New York, North Carolina, and Washington. CMS is working with model participants to address priorities specific to their communities, including care management for chronic conditions, behavioral health services, and health care access for rural residents. CMS is working with State Medicaid Agencies in the eight states to engage in full care transformation across public programs, with plans to engage private payers in the coming months. The model's flexible multi-payer alignment strategy allows CMS to build on existing state innovations and for all patients served by participating primary care clinicians to benefit from improvements in care delivery, financial investments in primary care, and learning tools and supports under the model. CMS Announces Multi-State Initiative to Strengthen Primary Care | CMS

While the premise that value-based reimbursement (VBR) supports overall reform on how health care is delivered and paid for, the transition for many rural hospitals and clinics to VBR is challenging. As a result of patient demographics, reimbursement models, market characteristics, and available services, rural hospitals are closing, and rural communities are losing services in higher proportion than urban communities. Effects of rural hospital closures and reduction of services reduce access to local available healthcare. Rural hospital closures result in a rise in emergency medical services costs, increased time and cost of transportation to healthcare services for patients, heightened transportation issues and barriers to care for vulnerable groups, and loss of jobs for hospital. (American Hospital Association: Rural Hospital Closures Threaten Access: rural-hospital-closures-threaten-access-report.pdf (aha.org), pages 5-7)

2. PERFORMANCE IMPLICATIONS

- Does this bill impact the current delivery of NMDOH services or operations?

  ☐ Yes ☒ No

- Is this proposal related to the NMDOH Strategic Plan? ☒ Yes ☐ No

  ☐ **Goal 1**: We expand equitable access to services for all New Mexicans

  ☐ **Goal 2**: We ensure safety in New Mexico healthcare environments

  ☒ **Goal 3**: We improve health status for all New Mexicans

  ☐ **Goal 4**: We support each other by promoting an environment of mutual respect, trust, open communication, and needed resources for staff to serve New Mexicans and to grow and reach their professional goals.

3. FISCAL IMPLICATIONS

- If there is an appropriation, is it included in the Executive Budget Request?

  ☐ Yes ☐ No ☒ N/A

- If there is an appropriation, is it included in the LFC Budget Request?

  ☐ Yes ☐ No ☒ N/A

- Does this bill have a fiscal impact on NMDOH? ☐ Yes ☒ No

4. ADMINISTRATIVE IMPLICATIONS

Will this bill have an administrative impact on NMDOH? ☐ Yes ☒ No

5. DUPLICATION, CONFLICT, COMPANIONSHIP OR RELATIONSHIP

None

6. TECHNICAL ISSUES

Are there technical issues with the bill? ☐ Yes ☒ No

7. LEGAL/REGULATORY ISSUES (OTHER SUBSTANTIVE ISSUES)

- Will administrative rules need to be updated or new rules written? ☐ Yes ☒ No
- Have there been changes in federal/state/local laws and regulations that make this legislation necessary (or unnecessary)? ☐ Yes ☒ No
- Does this bill conflict with federal grant requirements or associated regulations? ☐ Yes ☒ No
- Are there any legal problems or conflicts with existing laws, regulations, policies, or programs? ☐ Yes ☒ No

8. DISPARITIES ISSUES

New Mexico's health system poses certain challenges for improving the health status of the population as New Mexico's population is not evenly distributed across the state geographically. Of New Mexico's 33 counties, seven contain predominantly urban areas defined as part of Metropolitan Statistical Areas. The remaining 26 non-metropolitan counties are considered rural or frontier in nature (New Mexico Rural Health Plan: https://www.nmhealth.org/publication/view/report/5676/, page 3).

Due to current healthcare reimbursement systems, communities with a large proportion of low-income residents and rural communities may not generate sufficient paying demand to assure that providers will practice in these locations (2020-2022 New Mexico State Health Improvement Plan, page 4: nmhealth.org/publication/view/report/5676/). The rural to urban migration of health professionals inevitably leaves poor, rural, and remote areas underserved and disadvantaged. Skilled health professionals are increasingly taking job opportunities in the labor market in high-income areas as the demand for their expertise rises.

9. HEALTH IMPACT(S)

Population densities are categorically lower in rural areas, and as a consequence, rural hospitals have much lower patient volumes. Lower patient volumes make it challenging for rural hospitals to maintain fixed-operating costs. Lower patient volumes can also impede rural hospitals' participation in performance measurement and quality improvement activities. Rural providers may not be able to obtain statistically reliable results for some performance measures without meeting certain case thresholds, making it difficult to identify areas of success or areas for improvement. Additionally, quality programs often require reporting on measures that are not relevant to the low-volume, rural context. This can limit rural hospitals' participation in innovative payment models that can help improve patient outcomes and provide alternative streams of revenue. In addition to lower patient volumes, rural hospitals often treat patient populations that are older, sicker and poorer compared to the national average. (American Hospital Association: Rural Hospital Closures Threaten Access: rural-hospital-closures-threaten-access-report.pdf (aha.org), page 5).

10. ALTERNATIVES

None

11. WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL?

If SB 17 were not enacted, the Health Care Delivery and Access Act, creating the Health Care Delivery and Access Medicaid-Directed Payment Program and the Health Care Delivery and Access Fund, would not be created.

12. AMENDMENTS

None