| LFC Requester: | Allegra Hernandez |
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# AGENCY BILL ANALYSIS - 2026 REGULAR SESSION

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## SECTION I: GENERAL INFORMATION

***{Indicate if analysis is on an original bill, amendment, substitute or a correction of a previous bill}***

**Date Prepared:** 1/23/26 **Bill Number:** HB143 **Original** X **Amendment** **Substitute**
**Short Title:** HEALTH CARE CHANGES
**Sponsor:** Rep. Jenifer Jones
**Name and Code Number**: HCA 630
**Person Writing:** Keenan Ryan
**Phone:** 505-396-0223 **Email:** Keenan.Ryan@hca.nm.gov

## SECTION II: FISCAL IMPACT

### APPROPRIATION (dollars in thousands)

| Appropriation | | Recurring or Nonrecurring | Fund Affected |
|---|---|---|---|
| **FY26** | **FY27** | | |
| $0 | $0 | - | - |
| $0 | $0 | - | - |

(Parenthesis ( ) indicate expenditure decreases)

### REVENUE (dollars in thousands)

| Estimated Revenue | | | Recurring or Nonrecurring | Fund Affected |
|---|---|---|---|---|
| **FY26** | **FY27** | **FY28** | | |
| $0 | $0 | $0 | - | - |
| $0 | $0 | $0 | - | - |

(Parenthesis ( ) indicate revenue decreases)

**ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)**

| | FY26 | FY27 | FY28 | 3 Year Total Cost | Recurring or Nonrecurring | Fund Affected |
|---|---|---|---|---|---|---|
| FTE | $0.0 | $58.7 | $ 58.7 | $ 117.4 | Recurring | General Fund |
| FTE | $0.0 | $ 58.7 | $ 58.7 | $ 117.4 | Recurring | Federal Fund |
| | | | | | | |
| Contract | $0.0 | $ 1,250.0 | $ 1,250.0 | $ 2,500.0 | Recurring | General Fund |
| Contract | $0.0 | $ 1,250.0 | $ 1,250.0 | $ 2,500.0 | Recurring | Federal Funds |
| | | | | | | |
| ~~MAD Program~~ | ~~$0.0~~ | ~~$0.0~~ | ~~$ 617,000.0~~ | ~~$ 617,000.0~~ | ~~Recurring~~ | ~~General Fund~~ |
| ~~MAD Program~~ | ~~$0.0~~ | ~~$0.0~~ | ~~$ 2,213,354.0~~ | ~~$ 2,213,354.0~~ | ~~Recurring~~ | ~~Federal Funds~~ |
| | | | | | | |
| **TOTAL** | **$0.0** | **$ 2,617.4** | **~~$2,832,971.4~~ $2,617.4** | **~~$ 2,835,588.8~~ $5,234.8** | **Recurring** | **Total** |

(Parenthesis ( ) Indicate Expenditure Decreases)

**SECTION III: NARRATIVE**

**BILL SUMMARY**

Synopsis:

HB 143 addresses health care workforce incentives, Medicaid cost studies, and amends the Medical Malpractice Act. It expands individual income tax credits for rural practitioners and creates a new physician income tax credit. It establishes a Medical Residency Loan Repayment Act administered by HED and mandates periodic Medicaid cost studies by HCA. The bill amends the Medical Malpractice Act.

Section by Section Analysis

Section 1. Rural Health Practitioner Tax Credit. Increases the amounts of income tax credits from $5,000.00 to $15,000.00 and expands the health care occupations eligible for the credits.

Section 2. Physician Income Tax Credit. Establishes refundable income tax credit of up to $50,000 per year for up to five consecutive years that a physician practicing full-time in NM has an outstanding balance of a student loan taken for medical education.

Sections 3-9. Medical Residence Loan Repayment Act. As presently drafted, awards may be subject to treatment as taxable gross income to the recipients.

Section 10. Medicaid Cost Studies Required. Requires HCA to conduct cost studies at least every three years to determine cost of Medicaid reimbursable services.

Sections 11-14. Medical Malpractice Act amendments.
The bill would amend the Medical Malpractice Act to reduce per occurrence recovery (except for punitive damages and past/future medical care and related benefits) to $600,000 from existing limits and would eliminate adjustment of the limit for inflation. It would modify the definition of "occurrence" to mean all claims for damages from harm to a single patient regardless of the number of providers, errors, or omissions that contributed to the harm.

Payments made from the patient's compensation fund for medical care and related benefits would be made as expenses are incurred.

The bill would reduce personal liability of health care providers from $250,000 to $200,000 and require the Patient's Compensation Fund to pay all amounts above that limit. It would delete a provision that amounts due from a judgment or settlement against a hospital or outpatient facility shall not be paid from the fund.

Under HB143, punitive damages would require proof beyond a reasonable doubt of malice, willful intent to harm, or wanton disregard for the rights or safety of others. Punitive damages against a hospital or hospital-controlled outpatient facility would be capped at three times the limit on compensatory damages while those against other health care providers would be limited to the amount of compensatory damages.

The bill would establish a sliding scale for maximum attorney fees percentages allowed based upon the amount recovered, ranging from thirty percent of the first $250,000 to fifteen percent of a recovery greater than $1 million. It would provide that any amount recovered that is covered by the patient's compensation fund would not contribute to an attorney's contingency fee.

**FISCAL IMPLICATIONS**
Section 10. Medicaid Cost Studies: The cost of a Medicaid rate study varies significantly depending on the scope of the study, data collection needs, stakeholder involvement, and the consulting firm conducting the study. For example, in FY 2023, Medicaid conducted a comprehensive rate review that cost $1,000,000; the rate study of home and community-based services for the community benefit program in FY 2024 cost $300,000 and another rate study for the community-based services for 1915(c) waivers cost $500,000. For a rate study with a broad and thorough work scope as required by this bill, estimated cost is $2,500,000 per year; this cost is based on conducting a study covering one-third of the providers receiving a Medicaid payment each year as permitted by Section C of the bill by at least two vendors. The cost of the study will get federal match at 50% and it will cost the general fund $1,250,000 each year.

In addition, the Medicaid program would need additional staff to implement this bill for oversight

and collaboration with a vendor for cost-based rate studies. One (1) FTE at pay-band C8 would cost $117,300 with $58,650 coming from the general fund and $58,650 from federal funds.
~~In addition, the current Medicaid reimbursement rates are benchmarked with the Medicare fee schedule. Medicaid is currently paid between 100% to 150% of the Medicare rates for equivalent services. In FY25, the general fund cost to pay for increases in Medicaid reimbursement for maternal, behavioral health, and primary care rates from 120% to 150% percent of Medicare and to keep other rates at 100% of Medicare was $100,000,000 in general fund. If the rate studies result in reimbursing Medicaid providers an equivalent of 200% of the Medicare rates, excluding hospitals and nursing facilities, it would cost the Medicaid program $2,830,354,000 with $617,000,000 general fund and $2,213,354,000 federal funds. Hospitals have been excluded from this impact as they receive the average commercial rate (ACR) through the Healthcare Delivery and Access Act and the nursing facilities are paid through the healthcare quality surcharge (HCQS) and cost rebasing.~~

The overall recurring cost of implementing HB ~~400~~ 143 is potentially ~~$2,832,971,400~~ $2,617.4 thousand a year, supported by ~~$618,308,700~~ $1,308.7 thousand from the general fund and ~~$2,214,662,700~~ $1,308.7 thousand by federal funds.

**SIGNIFICANT ISSUES**
This bill includes several policies affecting the larger healthcare ecosystem. They include adjustments to tax policy, loan repayment, medical malpractice, and mandating cot studies for Medicaid. The sum of these proposals may support provider recruitment and retention.

Section 10. Medicaid Cost Studies: The Medicaid program has been using the Medicare fee schedule as the benchmark to raise provider reimbursement rates for services that have Medicare equivalence and average rate increase or targeted raise increase for services that Medicare does not cover. The provider reimbursement rate increase is at 100% to 150% of the Medicare rate based on legislative appropriations for FY 2024 and FY 2025. The requirement of this bill would be a new reimbursement rate-setting methodology for health care providers serving the Medicaid population. This new reimbursement methodology will also require a revision to the State Plan and NMAC. The state plan amendment approval process takes at least six (6) months to obtain approval from the Centers for Medicare and Medicaid Services (CMS).

**PERFORMANCE IMPLICATIONS**
Depending on the outcomes of periodic Comprehensive Rate Studies, provider rate increases may become operational through HB2 appropriations from the general fund. The example described above involved Medicaid rate adjustments benchmarked to the Medicare fee schedule, ranging between 100% to 150% of the Medicare rates for equivalent services. In operation the adjustment resulted in a very aggressive increase in Medicaid reimbursement across New Mexico's health care provider network, with an estimated cost of $115,061.7 thousand to the state general fund.

**ADMINISTRATIVE IMPLICATIONS**
House Bill (HB) 395 of the 2023 regular legislative session amended Section 28-16A-16 NMSA

1978 requiring the Department of Health (DOH) to conduct a biennial independent cost study for recommending reimbursement rates for the 1915(c) waivers – Developmentally Disabled (DD), Medically Fragile (MF) and Mi Via Waivers. The rate study required by HB ~~400~~ 143 would be duplicative.

Similarly, the Early Childhood Education and Care Department (ECECD) undergoes a separate rate study process for the Family Infant Toddler (FIT) program. This rate study is funded by ECECD. Any inclusion of these providers in general Medicaid rate studies would be duplicative.

In addition, the Medicaid program reimburses certain provider types at cost. The Medicaid School-Based Services (MSBS) program utilizes a cost-based reimbursement methodology. The MSBS providers are paid with interim rates and at the end of the year, they file an annual cost report to determine the actual cost of providing services. The provider either receives additional Medicaid payment if the interim payment is less than the actual cost or returns payment to the Medicaid program if the interim payment is greater than the actual cost. Thus, MSBS providers do not need to be included in general Medicaid rate studies.
Hospitals and home health are also subject to cost settlement on fee-for-service (FFS). Hospitals are paid with interim rates, usually a cost to charge ratio, during the hospital's fiscal year. At the end of the fiscal year, the hospitals submit a cost report to the Medicaid program's auditing agent. The audit results in no additional payment ~~of~~ if the interim payment equals the cost of providing services for that year. The audit results in additional payment if the interim payment is less than the cost of providing services. Consequently, a payment is returned to the Medicaid program if the interim payment is greater than the cost of providing services. Thus, hospitals do not need to be included in general Medicaid rate studies.

**CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP**
HB400 (2025)

House Bill 395 from the 2023 legislative regular session required the Department of Health to conduct a biennial rate study. The proposed timing of the rate studies in HB ~~400~~ 143 conflicts with this prior mandate.

**TECHNICAL ISSUES**
Line 6 and 7 on page 16, the cost study as being for "each type of health care provider." Providers are reimbursed based on the services provided not the enrollment type. It would be more accurate to define a cost study for "each type of service."

**OTHER SUBSTANTIVE ISSUES**
None

**ALTERNATIVES**
None

**WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL**
Status Quo

**AMENDMENTS**

None