LFC Requester:	Julisa Rodriguez

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: 1/17/26 **Bill Number:** SB0016 **Original** X **Amendment** **Substitute**
Short Title: HEALTH PROFESSIONAL AUTONOMY ACT
Sponsor: Sen. Sedillo Lopez
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	NA	NA

(Parenthesis ( ) indicate expenditure decreases)

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Nonrecurring	Fund Affected
FY26	**FY27**	**FY28**		
$0.0	$0.0	$0.0	NA	NA

(Parenthesis ( ) indicate revenue decreases)

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY26	FY27	FY28	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Program	$0.0	$124,756.0	$150,940.5	$275,696.5	recurring	State fund
Program	$0.0	$312,524.0	$378,118.3	$690,642.3	recurring	Federal fund
Total	$0.0	$437,280.0	$529,058.8	$966,338.8		Total Cost

(Parenthesis ( ) Indicate Expenditure Decreases)

SECTION III: NARRATIVE

BILL SUMMARY

Synopsis: The "Health Professional Autonomy Act" (SB232466) creates a prohibition against health care entities interfering with, controlling, or otherwise directing the judgment or clinical decisions of health care providers. The act defines "health care entities" broadly to include a "person that provides or supports the provision of health care services to patients in New Mexico" with an exclusion for a federally qualified health center or an "independent health care practice" which is defined as an organization owned or controlled by health care providers.

The prohibitions of the Act are enforced through both a private right of action and enforcement by the Attorney General, including injunctive relief. The private right of action applies broadly to "a person who has suffered injury by reason of an act or practice in violation" of the Act and so provides a statutory cause of action, allowing a patient to sue a health care entity for the consequences of that entity's actions against their employee or contractor.

FISCAL IMPLICATIONS

Title XIX (Medicaid) is an entitlement program and Title XXI (Children's Health Insurance Program (CHIP)) is an optional program, which must be reauthorized and make appropriation by the United States Congress periodically. Both Medicaid and CHIP are governed by federal statutes, regulations and rules. The New Mexico Medicaid program (Medicaid and CHIP) operates under a State Plan approved by the Centers for Medicare and Medicaid Services (CMS) in accordance with federal statutes, regulations and rules. Medicaid covered services are specified in the State Plan, including safeguards such as prior authorization and service limitations to minimize unintended consequences, such as supply or demand induced services. Federal regulations permit the application of prior authorization for certain items or services to make sure the items or services are medically necessary and clinically appropriate. SB 16 would remove these safeguards, potentially resulting in a significant increase in cost to the Medicaid program.

In addition, Medicaid 1915c waiver services are provided based upon a Level of Care and budgetary need that are reviewed and approved by the third-party assessor (TPA) in accordance with the CMS-approved waiver. For a waiver to be approved, in accordance with section 1915(c)(2)(D) of the Act and 42 CFR § 441.302(e), the HCA must demonstrate to the satisfaction of CMS that the waiver is cost-neutral during each year that the waiver is in effect. Section 1915(c)(2)(D) of the Act requires the HCA assure the average per capita expenditure under the

waiver during each waiver year not exceed 100 percent of the average per capita expenditures that would have been made during the same year for the level of care provided in a hospital, nursing facility, or Intermediate Care Facilities for Individuals with Intellectual Disabilities under the state plan had the waiver not been granted. 42 CFR § 441.302(e) requires the expenditures upon which the cost neutrality is based be reasonably estimated and well documented and that the estimate must be annualized and cover each year of the waiver period.

SB16 does not specifically address whether 1915c waiver services are included, however eliminating the prior authorization requirement for 1915c waiver services could significantly increase costs and thus impact HCA's ability to maintain cost-neutrality.

Overall, the value of Medicaid denied claims with prior authorization indicator was $384,036.6 thousands in FY 2024. Without prior authorization requirements, the denied claims would have been paid. Applying the same denied claims information in FY 2027 and FY 2028, would have a fiscal impact of $274,471.0 thousand each year, supported by an annual federal fund need of $274,471.0 thousand and an annual general fund need of $109,565.6 thousand.

Additionally, Medicaid would have to cover medications not currently covered. This could include agents with minimal clinical evidence of services Medicaid does not typically cover. Under this bill, Medicaid would be required to authorize these medications. In FY 2027 this additional fiscal impact is estimated to be $53,243.4 thousand, supported by $38,053.1 thousand in federal funds and $15,190.3 thousand in general funds. In SFY28 the cost is expected to increase to $145,022.2 thousand, supported by $103,647.4 thousand in federal funds and $41,374.8 thousand in general funds. These additional costs are estimated assuming there are roughly 66,231 Medicaid members with obesity, an uptake of 12% per year, and a 30% discontinuation rate.

SIGNIFICANT ISSUES

This bill would largely remove all form of checks and balances in the health care system. This presents significant issues related to patient safety and overall healthcare cost. For example, the profession of pharmacy within the medical space has a responsibility to review all prescriptions to be safe and effective for the patient. It is not clear under this bill whether pharmacists would be allowed to intervene on prescriptions with clinical concerns. Additionally, many pharmacists advise patients on cheaper alternatives. By doing so this could be construed as interfering with the autonomy of the original prescription and not allowed.

Also, hospitals and healthcare facilities implement a variety of clinical initiatives that limit "treatment options available to the patient" largely to increase patient safety and efficacy. For example, the use of computerized physician order entry (CPOE) is the use of a digital system that allows healthcare providers to enter medical orders. These systems often limit and or restrict what a provider can order to facilitate optimal care. A systematic review found CPOE were associated with a reduction in medical errors by 54-92%. Under this legislation these programs may be construed as interference. https://doi.org/10.1136/bmjqs-2019-010436

Additionally, the definition of "injury" as currently defined in SB16 is unclear whether the Act's remedies are intended to apply only to patients who experience bodily injury or also includes healthcare professionals who are subjected to employment actions and/or malpractice claims as a

result of an entity's violation of the Act.

Furthermore, Section 3(B)(2) appears to prohibit health care entities from participating in selecting, hiring, or firing "health care providers, allied health staff or medical assistants based, in whole or part, on clinical competency or proficiency." However, employers of health care providers in New Mexico can be held vicariously liable for their employees' negligent conduct, including conduct related to their clinical competency or proficiency. *See Spencer v. Health Force, Inc.*, 2005-NMSC-002, ¶¶ 8, 18-26, 137 N.M. 64 (denying a home health care company summary judgment on a negligent hiring, supervision, and retention claim because it had a duty to with regard to the actions of its agents to protect disabled persons under its care); *see also Trujillo v. Presbyterian Health Services*, 2025-NMSC-017, ¶ 26 (reinstating vicarious liability claims against the defendant hospital, even though medical negligence claims against its agents had been voluntarily dismissed).

Finally, Section 3B 1-4 pertains to how providers oversee patient care. Provider oversight could be related to quality reports, root cause analysis, peer review, or comparison of similar providers in similar situations related to utilization of test, procedures and medications. Item 4 of this section gives the provider the ability to not cover patients or potentially see too many patients and not provide complete care.

PERFORMANCE IMPLICATIONS
See Fiscal Implications, Significant Issues, and Administrative Implications.

ADMINISTRATIVE IMPLICATIONS
To effectuate this change, HCA would need to request, negotiate and receive federal Medicid waiver and state plan amendment approval, a process that can months to years, depending on the complexity of the change. Additionally, HCA would need to update multiple NMACs, MCO contracts and MCO guidance, as well as make IT system updates. Ongoing oversight would be required for HCA to reconcile requirements of this bill with federal coding edits such as medically unlikely edits (MUE) which identify the maximum units of service. IT changes needed for the claims system will be made at no additional cost.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP
Similar to SB450 introduced in 2025.

TECHNICAL ISSUES
None

OTHER SUBSTANTIVE ISSUES
Licensed health care professionals are already expected to adhere to ethical duties to their patients that are paramount to the duties owed to their employers. As a result, provider associations like the American Medical Association recommend that their members include a provision in their employment contracts acknowledging their right to advocate for patients and protecting their clinical judgement even when their clinical recommendations are not advantageous to their employer.

States such as Texas, California, and North Carolina avoid divided loyalty between the interests of a corporate health care entity and the needs of a patient by mandating that all stock in a corporation providing medical services be held by a physician licensed in the state and all members of the board of directors be physicians licensed by the state.

ALTERNATIVES
None suggested

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL
Status quo

AMENDMENTS
None