SENATE BILL 541

50TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2011

INTRODUCED BY

Stuart Ingle

AN ACT

RELATING TO HEALTH CARE; ENACTING THE HOSPITAL PROVIDER FEES ACT; PROVIDING FOR HOSPITAL PROVIDER FEES; MAKING AN APPROPRIATION.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. SHORT TITLE.--This act may be cited as the "Hospital Provider Fees Act".

SECTION 2. LEGISLATIVE FINDINGS.--The legislature finds and declares that:

A. the state and the providers of publicly funded medical services, and hospital providers in particular, share a common commitment to provide access to health care and hospital services regardless of a person's ability to pay for such services;

B. hospital providers within the state incur

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significant costs by providing health care and other medical services to:

(1) those eligible for medicaid in return for payments less than the cost of care; and

(2) other low-income and uninsured populations without receiving any compensation; and

C. the Hospital Provider Fees Act is enacted in part to ensure access to health care and hospital services and is intended to provide the following state services and benefits:

(1) providing an additional payer source for some low-income and uninsured populations who may otherwise be cared for in emergency departments and other settings in which uncompensated care is provided;

(2) reducing the underpayment to New Mexico hospitals participating in publicly funded health insurance programs;

(3) reducing the number of persons in New Mexico who are without health care benefits;

(4) reducing the need of health care providers to shift the cost of providing uncompensated care to other payers; and

(5) expanding access to high quality, affordable health care for low-income and uninsured populations.

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SECTION 3. DEFINITIONS.--As used in the Hospital Provider Fees Act:

A. "board" means the provider fees oversight and advisory board;

B. "carrier" means a person that is subject to licensure by the superintendent of insurance or subject to the provisions of the New Mexico Insurance Code and that provides one or more health benefit or insurance plans in the state;

C. "department" means the human services department;

D. "hospital" means any general or special hospital licensed by the department of health, whether publicly or privately owned;

E. "medicaid" means the joint federal-state program to provide medical assistance to individuals pursuant to Title 19 and Title 21 of the federal Social Security Act;

F. "medicare" means the federal health coverage program established pursuant to Title 18 of the federal Social Security Act;

G. "provider fees" means assessments that the department makes upon hospitals that will be used to fund a portion of the medicaid program subject to the provisions of Section 4 of the Hospital Provider Fees Act;

H. "rural" means a county having thirteen thousand or fewer inhabitants as of the last federal decennial census;

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and

I. "safety-net hospital" means a hospital for which the percentage of medicaid-eligible inpatient days relative to its total inpatient days is equal to or greater than one standard deviation above the mean.

SECTION 4. PROVIDER FEES.--

A. Beginning with the fiscal year commencing July 1, 2011, and each fiscal year thereafter, the department is authorized to charge and collect provider fees on inpatient and outpatient services provided by licensed or certified hospitals for the purpose of obtaining federal financial participation pursuant to the medicaid program. Provider fees shall be used to:

(1) reduce the amount of underpayment to hospitals for providing medical care to medicaid and other low-income and uninsured populations;

(2) increase the number of persons covered by public medical assistance; and

(3) pay to the department the administrative costs incurred in implementing and administering this section.

B. The provider fees shall be assessed pursuant to rules promulgated by the department. The amount of the provider fees shall be established by rule of the department in a manner consistent with applicable federal law. In establishing the amount of the provider fees and in

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promulgating the rules governing the fees, the department shall:

(1) consider recommendations of the board pursuant to Section 7 of the Hospital Provider Fees Act; and

(2) establish the amounts of the provider fees so that the amounts collected from the fees as supplemented by federal matching funds associated with the fees are sufficient to pay for the items described in Subsection A of this section, but nothing in this paragraph shall require the department to increase the provider fees above the amounts recommended by the board.

C. In accordance with the redistributive method set forth in applicable federal law, the department may seek a waiver from the broad-based provider fees requirement or the uniform provider fees requirement, or both. Subject to federal approval, and to minimize the financial impact on certain hospitals, the department, in consultation with the board, may exempt from payment of the provider fees certain types of hospitals, including:

(1) psychiatric hospitals, as licensed by the department of health;

(2) hospitals that are both:

(a) licensed as general hospitals; and

(b) certified as long-term care hospitals by the department of health;

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(3) critical access hospitals that are licensed as general hospitals and are certified by the department of health pursuant to federal law;

(4) inpatient rehabilitation facilities; or

(5) hospitals specified for exemption pursuant to applicable federal law.

D. In determining whether a hospital may be excluded, the department shall use one or more of the following criteria:

(1) a hospital that is located in a rural area;

(2) a hospital with which the department does not contract to provide services pursuant to the medicaid program;

(3) a hospital whose inclusion or exclusion would not significantly affect the net benefit to hospitals paying the provider fees; or

(4) a hospital that must be included to receive federal waiver or plan amendment approval.

E. The department may reduce the amount of the provider fees for certain hospitals in order to obtain federal approval and to minimize the financial impact on certain hospitals. In determining for which hospitals the department may reduce the amount of the provider fees, the department shall use one or more of the following criteria:

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(1) the hospital is a type of hospital described in Subsection C of this section;

(2) the hospital is located in a rural area;

(3) the hospital serves a higher percentage in this state than the average hospital of persons covered by the medicaid program or persons enrolled in a medicaid managed care organization;

(4) the hospital does not contract with the department to provide services pursuant to the medicaid program;

(5) if the hospital paid reduced provider fees, the reduced provider fees would not significantly affect the net benefit to hospitals paying the provider fees; or

(6) the hospital is required not to pay reduced provider fees as a condition of federal approval.

F. The department may, with the approval of the board, alter the process prescribed in this section to the extent necessary to meet applicable federal requirements and to obtain federal approval.

G. The department, in consultation with the board, shall promulgate rules on the calculation, assessment and timing of the provider fees. The department shall assess the provider fees on a schedule to be set through rule. The department's rules shall require that the periodic provider fee payments from a hospital and the department's reimbursement to

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the hospital are due as nearly simultaneously as feasible, except that the department's reimbursement to the hospital shall be due no more than five days after the periodic provider fee payments are received from the hospital. If more than one hospital is owned by the same entity, the provider fees shall be imposed on each hospital that the entity owns in this state. The fees shall be prorated and adjusted for the expected volume of service for any year in which a hospital opens or closes.

H. The department, in consultation with the board, shall promulgate rules regarding the reports that hospitals shall be required to submit for the department to calculate the amounts of the provider fees. Notwithstanding the provisions of the Inspection of Public Records Act, information provided to the department pursuant to this section shall be considered confidential and shall not be deemed a public record. Nonetheless, the department, in consultation with the board, may prepare and release summaries of the reports to the public.

I. A hospital shall not include any amount of the provider fees as a separate line item in its billing statements.

J. The department shall adopt rules necessary for the administration and implementation of this section. Prior to adopting rules concerning the administration or implementation of the provider fees, the department shall consult with the board on proposed rules.

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SECTION 5. HOSPITAL PROVIDER FEES FUND.--

A. The "hospital provider fees fund" is created in the state treasury. The department shall administer the fund and may establish procedures and adopt rules as required to administer the fund consistent with the provisions of the Hospital Provider Fees Act. The fund consists of provider fees remitted by hospitals, matching funds provided by the federal government, appropriations, grants and money that otherwise accrues to the fund. Income from investment of the fund shall be credited to the fund. The fund shall be a separate and continuing fund, and money in the fund shall not transfer or revert to the general fund. Money in the fund shall be appropriated to the department only in accordance with the provisions of the Hospital Provider Fees Act. Disbursements from the fund shall be made only on warrants drawn by the secretary of finance and administration pursuant to vouchers signed by the secretary of human services or the secretary of human services' authorized representative.

B. All provider fees collected by the department pursuant to the Hospital Provider Fees Act shall be transmitted to the state treasurer, who shall credit the fees to the hospital provider fees fund.

C. All money in the hospital provider fees fund, as supplemented by federal matching funds authorized pursuant to applicable federal law, is appropriated for the following

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purposes:

(1) to maximize payments to hospitals for inpatient and outpatient services subject to the upper payment limits established by applicable federal law;

(2) to ensure adequate hospital reimbursements up to one hundred percent of the hospital's uncompensated care costs;

(3) to pay quality incentive payments as set forth by department rule;

(4) subject to available revenue from the provider fees as supplemented with federal matching funds, to expand eligibility for public medical assistance to persons not otherwise covered through federally matched programs; and

(5) to pay the department's actual administrative costs of implementing and administering the Hospital Provider Fees Act, including the following costs:

(a) expenses of the board, including the department's personnel services and operating costs related to the administration of the board;

(b) the department's actual costs related to implementing and maintaining the provider fees, including personal services, operating and consulting expenses;

(c) the department's actual costs for the changes and updates to the medicaid management information system for the implementation of Paragraphs (1) through (3) of

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this subsection;

(d) the department's operating costs related to personnel, consulting services and review of hospital costs and required reports necessary to implement and administer the increases in inpatient and outpatient hospital payments made pursuant to Paragraphs (1) and (2) of this subsection and quality incentive payments made pursuant to Paragraph (3) of this subsection;

(e) the department's actual costs for the changes and updates to the New Mexico benefits management system and medicaid management information system to implement and maintain the expanded eligibility provided for in Paragraph (4) of this subsection;

(f) the department's operating costs related to personnel necessary to implement and administer the expanded eligibility for public medical assistance provided for in Paragraph (4) of this subsection; and

(g) the department's operating and systems costs related to expanding the opportunity for individuals to apply for public medical assistance directly at hospitals or through another entity outside the county departments, in connection with Chapter 27, Article 5 NMSA 1978, that would increase access to public medical assistance and reduce the number of uninsured served by hospitals.

SECTION 6. APPROPRIATIONS FROM THE HOSPITAL PROVIDER FEES

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FUND.--

A. In the event the legislature reduces appropriations from the general fund to support the New Mexico medicaid program, the provider fees shall be reduced by an amount equal to the reduction in general appropriations.

B. If the revenue from the provider fee is insufficient to fully fund all of the purposes described in Subsection A of Section 4 of the Hospital Provider Fees Act:

(1) the hospital provider reimbursement and quality incentive payment increases described in Paragraphs (1) through (3) of Subsection C of Section 5 of the Hospital Provider Fees Act and the costs described in Paragraph (5) of Subsection C of Section 5 of that act shall be fully funded using revenue from the provider fees and federal matching funds before any eligibility expansion is funded; and

(2) if the department promulgates rules that expand eligibility for medical assistance to be paid for pursuant to Paragraph (4) of Subsection C of Section 5 of the Hospital Provider Fees Act, and the department thereafter notifies the board that the revenue available from the provider fees and the federal matching funds will not be sufficient to pay for all or part of the expanded eligibility, the board shall recommend to the department reductions in medical benefits or eligibility so that the revenue will be sufficient to pay for all of the reduced benefits or eligibility. After

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receiving the recommendations of the board, the department shall adopt rules providing for reduced benefits or reduced eligibility for which the revenue available from the provider fees, as supplemented with federal matching funds, shall be sufficient.

C. Notwithstanding any other provision of the Hospital Provider Fees Act, if, after receipt of authorization to receive federal matching funds for money in the fund, the authorization is withdrawn or changed so that federal matching funds are no longer available, the department shall cease collecting provider fees and shall renegotiate the medicaid rates that the department pays to hospitals, using the money that the department received in the hospital provider fees that is not subject to federal matching funds to augment medicaid reimbursement accordingly.

SECTION 7. PROVIDER FEES OVERSIGHT AND ADVISORY BOARD.--

A. There is hereby created the "provider fees oversight and advisory board", which is administratively attached to the department.

B. The board consists of thirteen members appointed by the governor, with the advice and consent of the senate, as follows:

(1) five members who are employed by hospitals in New Mexico, including at least one person who is employed by a hospital in a rural area, one person who is employed by a

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safety-net hospital and one person who is employed by a hospital in an urban area;

(2) one member who is a representative of a statewide organization of hospitals;

(3) one member who represents a statewide organization of health insurance carriers or a health insurance carrier licensed pursuant to the New Mexico Insurance Code and who is not a representative of a hospital;

(4) one member of the health care industry who does not represent a hospital or a health insurance carrier;

(5) one member who is a consumer of health care and who is not a representative or an employee of a hospital, health insurance carrier or other health care industry entity;

(6) one member who is a representative of persons with disabilities or who is living with a disability and who is not a representative or an employee of a hospital, health insurance carrier or other health care industry entity;

(7) one member who is a representative of a business that purchases or otherwise provides health insurance for its employees; and

(8) two employees of the department.

C. The governor shall consult with representatives of a statewide organization of hospitals in making the appointments pursuant to Paragraphs (1) and (2) of Subsection B

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of this section. No more than seven members of the board may be members of the same political party.

D. Members of the board shall serve at the pleasure of the governor. In making the appointments, the governor shall specify that four members shall serve initial terms of two years and three members shall serve initial terms of three years. All other terms, including terms after the initial terms, shall be four years. A member who is appointed to fill a vacancy shall serve the remainder of the unexpired term of the former member.

E. The governor shall designate a chair from among the members of the board appointed pursuant to Paragraphs (1) through (7) of Subsection B of this section. The board shall elect a vice chair from among its members.

F. Members of the board may receive per diem and mileage as provided for in the Per Diem and Mileage Act.

G. The board may direct the department to contract for a group facilitator to assist the members of the board in performing their required duties.

H. The board shall have, at a minimum, the following duties:

(1) to recommend to the department the timing and method by which the department shall assess the provider fees and the amounts of the fees;

(2) if requested by the New Mexico legislative

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council or the interim legislative health and human services committee, to consult with the legislative committees on any legislation that may affect the provider fees or hospital reimbursements established pursuant to the Hospital Provider Fees Act;

(3) to recommend to the department changes in the provider fees that increase the number of hospitals benefiting from the uses of the provider fees described in Paragraphs (1) through (4) of Subsection C of Section 5 of the Hospital Provider Fees Act or that minimize the number of hospitals that suffer losses as a result of paying the provider fees;

(4) to recommend to the department reforms or changes to the inpatient hospital and outpatient hospital reimbursements and quality incentive payments made pursuant to the medicaid program to increase provider accountability, performance and reporting;

(5) to recommend to the department the schedule and approach to the implementation of Paragraph (4) of Subsection C of Section 5 of the Hospital Provider Fees Act;

(6) if money in the hospital provider fees fund is insufficient to fully fund all of the purposes specified in Subsection C of Section 5 of the Hospital Provider Fees Act, to recommend to the department changes to the expanded eligibility provisions pursuant to Paragraph (4) of

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that subsection;

(7) to prepare the reports specified in Subsection I of this section;

(8) to monitor the impact of the provider fees on the broader health care marketplace in this state; and

(9) to perform any other duties required to fulfill the board's charge or those assigned to it by the department.

I. On or before January 15, 2012, and on or before January 15 each year thereafter, the board shall submit a written report to the New Mexico legislative council, the interim legislative health and human services committee, the legislative finance committee, the governor and the department. The report shall include:

(1) the recommendations made to the department pursuant to the Hospital Provider Fees Act;

(2) a description of the formula for how the provider fees are calculated and the process by which the provider fees are assessed and collected;

(3) an itemization of the total amount of the provider fees paid by each hospital and any projected revenue that each hospital is expected to receive due to:

(a) the increased reimbursements made pursuant to Paragraphs (1) and (2) of Subsection B of Section 5 of the Hospital Provider Fees Act and the quality incentive

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payments made pursuant to Paragraph (3) of Subsection C of that section; and

(b) the increased eligibility described in Paragraph (4) of Subsection C of Section 5 of the Hospital Provider Fees Act;

(4) an itemization of the costs incurred by the department in implementing and administering the provider fees; and

(5) estimates of the differences between the cost of care provided and the payment received by hospitals on a per-patient basis, aggregated for all hospitals, for patients covered by each of the following:

(a) the medicaid program;

(b) medicare; and

(c) all others payers.

SECTION 8. EFFECTIVE DATE.--The effective date of the provisions of this act is July 1, 2011.

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