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AGENCY BILL ANALYSIS
2024 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}

Check all that apply:

Original x **Amendment** ____
Correction ____ **Substitute** ____

Date 1/28/2024
Bill No: SB17

Sponsor: Senator Stefanics and Representative Gallegos

Short Title: HEALTH CARE DELIVERY AND ACCESS ACT

Agency Name and Code Number: Office of Superintendent of Insurance - 440

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SECTION II: FISCAL IMPACT

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Nonrecurring	Fund Affected
FY24	FY25		

(Parenthesis ( ) Indicate Expenditure Decreases)

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Nonrecurring	Fund Affected
FY24	FY25	FY26		

(Parenthesis ( ) Indicate Expenditure Decreases)

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY24	FY25	FY26	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total						

(Parenthesis ( ) Indicate Expenditure Decreases)

Duplicates/Conflicts with/Companion to/Relates to:
Duplicates/Relates to Appropriation in the General Appropriation Act

SECTION III: NARRATIVE

BILL SUMMARY

Synopsis: Creates the Health Care Delivery and Access Medicaid-Directed Payment Program and the Health Care Delivery and Access Fund. Imposes assessments on certain hospitals to be used for additional reimbursement to hospitals with the goal of improving and increasing access to health care services in the state.

ASSESSMENTS.

• Imposed on inpatient and outpatient hospital services provided by an eligible hospital (a non-federal licensed facility, excluding a state university teaching hospital or state-owned special hospital). The rate is calculated annually by the Health Care Authority(HCA) and is based on assessed days (the number of inpatient hospital days exclusive of Medicare days).

• Specifies reduced assessment rates for rural, special, and small urban hospitals.

• Hospitals are directed to pay the assessments to the Taxation and Revenue Department on a specified schedule

• The process for calculating assessment rates and conditions is detailed.

HEALTH CARE DELIVERY AND ACCESS MEDICAID-DIRECTED PAYMENT PROGRAM is created in HCA to be approved by the Centers for Medicare and Medicaid Services. Its purpose is to provide additional Medicaid funding for hospital services provided through Medicaid managed care organizations.

The HCA shall:
• Determine the funds required for disproportionate share hospital payments but for the impact of the Medicaid-directed payment program on the limit set by the federal Social Security Act; and direct a like amount of funds otherwise appropriated for the New Mexico Medicaid Program to fund the Medicaid-Directed Payment Program
• Set aside 40% of the Medicaid-Directed Payment Program funding for quality incentive payments to eligible hospitals, to replace the targeted access fee-for-service supplement payment program and the hospital value-based directed payment program
• Establish performance evaluation criteria for eligible hospitals
• Ensure that quality incentive payments made to eligible hospitals meet specified criteria
• Structure payments to hospitals for the portion of funding not used for quality incentive payments as a uniform rate increase, to be paid through Medicaid managed care organizations separately

• Make directed payments to managed care organizations of the uniform rate increase funding, and require management care organizations to make directed payments to hospitals within 15 days after receipt of payments from the HCA. The HCA may not reduce hospital payment rates made pursuant to Medicaid below those in effect on the effective date of this act
• Require reports from eligible hospitals that demonstrate that the increase in payment for Medicaid managed patients provided through the Medicaid-directed payment program has enabled it to invest at least 75% of its net new funding into the delivery of health care services in the state.

HEALTH CARE DELIVERY AND ACCESS FUND is a nonreverting fund administered by the HCA, to be used for the following purposes:
• At least 90% for non-federal share of the Medicaid-directed payment program
• No more than 10% for administrative costs
• For refunds to eligible hospitals in proportion to the assessment amounts paid by the hospitals if there is a determination that the assessment is not a permissible source of non-federal Medicaid program expenditures or if a substantial portion of the federal funding for the directed payments is disallowed.

Requires TRD to make a distribution to the Fund of the net receipts of assessments and any associated interest or penalties.

DELAYED REPEAL. Calls for a repeal of the Health Care Delivery and Access Act effective July 1, 2030.

CONTINGENT EFFECTIVE DATE: The Health Care Delivery and Access Act becomes effective on the first day of the month subsequent to the HCA receiving the necessary federal authorizations and approval of waivers required to implement the act.

PERTINENT DEFINITIONS include:

“managed care organization" means a person or organization that has entered into a comprehensive risk-based contract with the authority to provide health care services, including inpatient and outpatient hospital services, to Medicaid beneficiaries.

"quality incentive payments" means the portion of the Medicaid-directed payment program paid to hospitals based on value-based quality measurements and performance evaluation criteria, as established by the HCA.

"rehabilitation hospital" means a facility licensed as a rehabilitation hospital by the Department of Health.

"rural hospital" means a hospital that is located in a county that has a population of 125,000 or fewer according to the most recent federal decennial census.

"small urban hospital" means a hospital that is located in a county that has a population greater than 125,000 and that has fewer than 15 licensed inpatient beds as of January 1, 2024.

"special hospital" means a facility licensed as a special hospital by the Department of Health.

"uniform rate increase" means the portion of the Medicaid-directed payment program paid to hospitals as a uniform dollar or percentage increase.

FISCAL IMPLICATIONS

None.

SIGNIFICANT ISSUES

SB 17 could have significant positive impacts on hospitals' ability to maintain solvency, increase wages for health care providers, and attract new providers to the state. The reimbursement rates paid by private health insurers, which are ultimately passed down to consumers and employers in the form of higher premiums and deductibles, are significantly higher than the rates currently reimbursed by public programs. Hospitals have attributed these higher payment rates to underpayments in Medicaid and Medicare. According to the Kaiser Family Foundation, the average rate paid by private insurers for all hospital services is nearly double what is reimbursed by Medicare. If Medicaid reimbursement rates are increased to the level contemplated in SB 17, consumers and employers in the private market should experience some relief, as the justification for charging higher rates to private insurers should no longer be valid. However, there is no direct mechanism to ensure that SB 17 will result in lower prices charged to privately insured consumers and businesses.

PERFORMANCE IMPLICATIONS

None.

ADMINISTRATIVE IMPLICATIONS

None.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

None.

TECHNICAL ISSUES

None.

OTHER SUBSTANTIVE ISSUES

None.

ALTERNATIVES

None.

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL

Funds for additional reimbursement to hospitals will not be available to for the improvement and increased access to health care services in New Mexico.

AMENDMENTS

OSI recommends establishing a task force or other body convened for the purpose of monitoring reimbursement rates charged to private insurers that will, by 2026, report to the HCA and OSI on trends in private insurer reimbursement following the passage of SB 17 and make recommendations on policies to be adopted to ensure that consumers and employers are not charged exorbitant rates.