LFC Requester:	

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 ___ **Amendment** ___
Correction x **Substitute** ___

Date 1/27/24
Bill No: SB17

Sponsor: Sen. Stefanics
Health Care Delivery and Access Act
Short Title:

Agency Name and Code Number: HSD-630 Paoze Her

Person Writing Analysis: Rayna Fagus, Carlos Ulibarri, Elisa Walker-Moran, Paoze Her
Phone: C:715-0486 **Email** Rayna.fagus@hsd.nm.gov

SECTION II: FISCAL IMPACT

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Nonrecurring	Fund Affected
FY24	**FY25**		
0	0	N/A	N/A
0	0	N/A	N/A

(Parenthesis ( ) Indicate Expenditure Decreases)

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Nonrecurring	Fund Affected
FY24	**FY25**	**FY26**		
0	$ 354,483.0	$ 363,699.6	R	Hospital Assessment

(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	$0.0	$ 354,483.0	$ 363,699.6		Recurring	Hospital Assessment
	$0.0	$1,326,327.8	$1,360,812.3		Recurring	Federal Funds
	$0.0	$1,680,810.8	$1,724,511.9			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:

Senate Bill 17 (SB 17) would create the Health Care Delivery and Access Act (HDAA). The Health Care Authority (HCA) would issue rules to carry out the provisions of the HDAA, seek a waiver and/or state plan amendment from the federal Centers for Medicare and Medicaid Services (CMS) to implement the provisions of the HDAA by July 15, 2024 (Section 12), and request an approval from CMS to operate the Medicaid directed payment program each year (Section 7). SB 17 would create the "health care delivery and access fund", a nonreverting fund in the state treasury that would be administered by the HCA. At least ninety percent (90%) of this fund is for the Medicaid directed payment programs and up to ten percent (10%) for administrative costs of administering the HDAA (Section 4).

Money of the "health care delivery and access fund" comes from an assessment of occupied, non-Medicare inpatient hospital bed days and net revenue from non-Medicare outpatient hospital services provided by eligible hospitals (Sections 3 and 9). The assessment rates are to be established by the HCA annually at rates that will generate a total revenue, in addition to any balance in the fund, to support directed payment to eligible hospitals up to the average commercial rate (ACR) or a maximum rate set by CMS. The assessment for July 1, 2024 to December 31, 2024, is for a full year. Rural and special hospitals get a 50% discount; small urban hospitals with fewer than 15 licensed beds as of January 1, 2024, get a 90% discount. The assessment is imposed only in periods that CMS has approved the waiver or applicable authority for the state to use the assessment as the state share for Medicaid directed payment. The HCA is to notify the eligible hospitals by November 1, 2024 for the period of July 1, 2024 to December 31, 2024, and by November 1 each calendar year thereafter. The assessment is refunded to the eligible hospitals if the assessment cannot be used as the state share, or a large portion of the directed payments is disallowed by CMS.

The distribution of the quality incentive payments (Section 5(B)(5) and (6)) is provided in Table 1 below.

Table 1: Quality Incentive Payment Based on Quality Measurements and Performance Evaluation

Description	General Acute Hospitals	Special Hospitals
Payment Only Based on Quality Measurements	Prior to Calendar Year 2026	Prior to Calendar Year 2027
Payment Based on Quality Measurements and Performance Evaluation	Calendar Year 2026 and Thereafter	Calendar Year 2027 and Thereafter

SB 17 also creates the health care and delivery and access Medicaid-directed payment program in HCA. HCA is to determine the fund needs to make a disproportionate share of hospital (DSH) payments, evaluate the impact of HDAA on federal DSH funding, and the total funds available. Forty percent (40%) of the fund is set aside for quality incentive payments based on established quality measurements and performance criteria. The assessment due date and directed payment paid date (Section 6(A), (B), and (D)) are summarized in Table 2 below.

Table 2: Assessment Due to Taxation and Revenue Department and Directed Payment Makes to Managed Care Organizations

	Hospitals Pay Assesstment		HCA Pays Managed Care Organizations	
Description	Uniform Rate Increase	Quality Incentive Payment	Uniform Rate Increase	Quality Incentive Payment
July 1 to December 31, 2024 Period	March 10, 2025	May 10, 2025	March 15, 2025	May 15, 2025
Calendar Year 2025 and Thereafter	70 Days After the Quarter End (One Payment)	May 10 of the Subsequent Year	75 Days After the Quarter End (Quarterly Payment)	May 15, 2025

The managed care organizations must pay the hospitals within fifteen (15) days after receipt of the directed payments from HCA. Also, the HCA can request eligible hospitals to submit an annual report that indicates an investment of greater than seventy-five percent (75%) of this funding source on health care delivery and access in the state.

The Taxation and Revenue Department (TRD) is to collect and enforce the health care delivery and access assessment (Sections 3 and 8).

Section 11 prohibits the HCA and the managed care organizations from reducing the hospital payment rates below the rates in effect on the date the HDAA takes effect.

Sections 1 to 11 are effective on the first day of the month subsequent to the HCA receiving CMS approvals of waivers required to implement and administer the HDAA (Section 14) and repeal effective July 1, 2030 (Section 13).

FISCAL IMPLICATIONS

SB 17 imposes an assessment on occupied, non-Medicare inpatient hospital bed days and net revenue from non-Medicare outpatient hospital services provided by eligible hospitals. Rural (acute care) and special hospitals (LTAC, Psych, Rehab) get a 50% discount and small urban hospitals (two non-Medicaid providers) get a 90% discount provided that the assessment with the discounts qualifies for a waiver of the uniformity requirement specified by federal regulations. Ten percent (10%) of the revenue from this assessment can be used for administrative expenses. The current hospital value-based program, targeted access payment funds (previously hospital access program and health care quality improvement initiative) are being rolled into this new healthcare

assessment program. This amount is currently $18.1 million general funds.

The analysis recognizes an implied inpatient (IP) day cost of $228.05 for non-Medicare bed days (637,540 bed days assumed) and a 6% assessment on non-Medicare net outpatient (OP) revenue, consistent with eligible hospital reimbursement up to the average commercial rate (ACR). The ACR is used for an Upper payment limit (UPL) benchmark by CMS. The UPL establishes a maximum limit on aggregate fee-for-service payments. The revenue estimate is based on hospital cost-report data for FY 2022 applying a two-year cumulative trend of 7.54% to the 2024 Base year.

Summary of Hospital Assessment and Funding (Number of Observations: 47 Hospitals)			
	BASE	**Implementation Dates**	
Description	**FY 2024**	**FY 2025**	**FY 2026**
EXISTING FUNDS from HVBP/HAP/TAP/HQII moving to New Program	18,101,871		
New Money for New Program	327,398,129		
Total Projected Assessment	345,500,000	354,483,000	363,699,558
Non-Medicare Bed Days -Assessment 1	145,388,349	149,168,447	153,046,826
Non-Medicare Net Outpatient Revenue -Assessment 2	200,111,651	205,314,553	210,652,732
Minus: Administrative Cost Allowance	(34,550,000)	(35,448,300)	(36,369,956)
Equal: Available Amount for Directed Payment for Eligible Hospitals	310,950,000	319,034,700	327,329,602
Total Computable for Eligible Hospitals (with Blended FMAP 78.91%)	1,474,395,448	1,512,729,730	1,552,060,703
Federal Financial Participation (FFP)	1,163,445,448	1,193,695,030	1,224,731,101
State Share	310,950,000	319,034,700	327,329,602
Hospital Payment - Access/Utilization (60% of Total Computable)	884,637,269	907,637,838	931,236,422
Hospital Payment - Quality Incentive (40% of Total Computable)	589,758,179	605,091,892	620,824,281
Total Computable for Administrative Cost Allowance	(163,821,716)	(168,081,081)	(172,451,189)
Federal Financial Participation (FFP)	(129,271,716)	(132,632,781)	(136,081,233)
State Share	(34,550,000)	(35,448,300)	(36,369,956)
HCA Portion of Administrative Expenses (1% of Projected Assessment)	3,455,000	3,544,830	3,636,996
Total (Directed Payment for Eligible Hospitals + Administration)	**1,638,217,165**	**1,680,810,811**	**1,724,511,892**
Federal Financial Participation (FFP)	**1,292,717,165**	**1,326,327,811**	**1,360,812,334**
State Share	**345,500,000**	**354,483,000**	**363,699,558**

The projected assessment is implemented in FY 2025 based on the FY 2024 base assessment calculations. Between FY 2024 and FY 2026 the analysis applies a 2.6% year-over-year trend. The

summary table below provides the estimated assessment amounts and their uses. In FY 2025, the base assessment amount would be $354.5 million across 47 hospitals. This estimate includes an assessment amount of $149.2 for inpatient services, and an estimated assessment amount of $205.3 million for outpatient services. The analysis deducts ten percent (10%) from the total base assessment for administrative expenses, that is $35.4 million covering underwriting gain & premium tax (9%), and HCA/MAD administrative costs (1%). Thus, the projected assessment amount remaining to support directed payments to eligible hospitals would be $319.0 million; that amount would support up to $1.5 billion in total computable payments (including $1.2 billion of federal share with a FMAP of 78.91%). Upon implementation in FY 2025 the projected directed payments would provide eligible hospitals $907.6 million for enhancing access/utilization of services and $605.1 million for quality incentive payments.

The total assessment in FY 2026 is $363.7 million with $153.0 million for IP services and $210.7 million for outpatient services. The ten percent (10%) administration expenses deduction is $36.4 million. Thus, the assessment amount remaining to support directed payments to eligible hospitals is $327.3 million; this amount will support up to $1.6 billion in total directed payments, of which $1.2 billion is the federal share applying a 78.91% blended FMAP. In the year following implementation, FY 2026, the projected directed payments would provide eligible hospitals $931.2 million for enhancing access/utilization of services and $620.8 million for quality incentive payments.

The calculation of the federal funds is based on anticipated paid date as the federal matched rate is applied on date of payment, except payments made to public providers. Thus, actual federal funds may differ when the calculation is made with known paid date.

The hospitals subject to the assessment is provided below:

Facility Name	Prov Class
ALTA VISTA REGIONAL HOSPITAL	R/Acute
SAN JUAN REGIONAL MEDICAL CENTER	R/Acute
ESPANOLA HOSPITAL	R/Acute
PLAINS REGIONAL MEDICAL CTR - CLOVIS	R/Acute
ARTESIA GENERAL HOSPITAL	R/Acute
LOS ALAMOS MEDICAL CENTER	R/Acute
REHOBOTH MCKINLEY CHRISTIAN HOSPITAL	R/Acute
CARLSBAD MEDICAL CENTER	R/Acute
COVENANT HEALTH HOBBS HOSPITAL	R/Acute
GUADALUPE COUNTY HOSPITAL	R/Acute
ROOSEVELT GENERAL HOSPITAL	R/Acute
LOVELACE REGIONAL HOSPITAL-ROSWELL	R/Acute
SIERRA VISTA HOSPITAL	R/Acute
SOCORRO GENERAL HOSPITAL	R/Acute
DR. DAN C. TRIGG	R/Acute
UNION COUNTY GEN. HOSPITAL	R/Acute
NOR-LEA HOSPITAL	R/Acute
LINCOLN COUNTY MEDICAL CENTER	R/Acute
MINER OF COLFAX MEDICAL CENTER	R/Acute
CIBOLA GENERAL HOSPITAL	R/Acute
MIMBRES MEMORIAL HOSPITAL	R/Acute
HOLY CROSS HOSPITAL	R/Acute
GILA REGIONAL MEDICAL CENTER	R/Acute
GERALD CHAMPION REGIONAL MEDICAL CTR	R/Acute
EASTERN NEW MEXICO MEDICAL CENTER	R/Acute
ENCOMPASS HEALTH REHABILITATION HOSP	U/Rehab
LOVELACE REHABILITATION HOSPITAL	U/Rehab
REHABILITATION HOSPITAL OF SOUTHERN	U/Rehab
CLEARSKY REHAB HOSPITAL OF RIO RANCH	U/Rehab
KINDRED HOSPITAL ALBUQUERQUE	U/LTAC
ALBUQUERQUE - AMG SPECIALTY HOSPITAL	U/LTAC
ADVANCED CARE HOSPITAL OF SOUTHERN N	U/LTAC
BHC MESILLA VALLEY HOSPITAL LLC	U/Behavioral
THE PEAK HOSPITAL	U/Behavioral
HAVEN BEHAVIORAL SEN CARE OF ALBUQUR	U/Behavioral
CENTRAL DESERT BEHAVIORAL HH	U/Behavioral
ST. VINCENT HOSPITAL	U/Acute
LOVELACE MEDICAL CENTER- DOWNTOWN	U/Acute
LOVELACE WOMENS HOSPITAL	U/Acute
MEMORIAL MEDICAL CENTER	U/Acute
PRESBYTERIAN HOSPITAL	U/Acute
LOVELACE WESTSIDE HOSPITAL	U/Acute
MOUNTAIN VIEW REG MED CTR	U/Acute
SANTA FE MEDICAL CENTER	U/Acute
THREE CROSSES REGIONAL HOSPITAL	U/Acute
Albuquerque ER and Medical Hospital - Coors (non-Medicaid, will pay 10% of tax, no redistribution)	Sm. U/Acute Non-Medicaid
Albuquerque ER and Medical Hospital - Montgomery (non-Medicaid, will pay 10% of tax, no redistribution)	Sm. U/Acute Non-Medicaid

SIGNIFICANT ISSUES

Under current federal regulations, states may not use provider tax revenues for the state share of Medicaid spending unless the tax meets three requirements: (1) It must be broad-based; (2) uniformly imposed; and (3) cannot hold providers harmless from the burden of the tax. Federal regulations create a safe harbor from the hold harmless test for taxes where collections are 6 percent or less of net patient revenues.

The creation of the HealthCare Delivery and Access Medicaid-Directed Payment Program by the HDAA will provide an increase in total payment to eligible hospitals. The increase in payment is designed to reimburse eligible hospitals up to the ACR. Currently, CMS will not allow Medicaid

hospital reimbursement to be made in excess of the ACR under managed care programs. Consequently, the increase in payment specified in the HDAA will affect the following enhanced payment programs currently operated by the New Mexico Medicaid program:

- *Medicaid DSH* – The increased reimbursement under the HDAA will cause most of the hospitals currently receiving disproportionate share hospital (DSH) payment to exceed the calculated hospital specific limit. As a result, those hospitals will no longer receive DSH payment and the federal DSH allotment will be reduced or eliminated.

- *Graduate Medical Education (GME) and Indirect Medical Education (IME)* – The GME program will continue to pay the same amount per FTE for eligible hospitals, and IME will not be directly impacted unless the tax program changes reimbursement rates.

- *Hospital Access Program (HAP) and Hospital Value-Based Payment program (HVBP)* – To pay for this increase in reimbursement, the hospital assessment program is increasing the tax to 6% which will have an impact per hospital. This will affect the state by increasing the funds available to the state to make federal participation matches with. Current HAP/HVBP payments would roll into the new program, essentially sunsetting the HAP/HVBP program but maintaining state funds that would be redirected to the new payment program.

- *Targeted Access Payments (TAP)* – These payments will be sunset when the provisions of HDAA goes into effect.

PERFORMANCE IMPLICATIONS

SB17 could help to alleviate the financial pressures and create greater stability for New Mexico's rural hospitals. In New Mexico – aligning with national trends – rural hospitals continue to be at a heightened risk of closure because they have high fixed costs with relatively low patient volume. These hospitals are critical access points for Medicaid patients, in particular, who often live in rural communities. In order to contain costs, many rural facilities have had to shut down or limit specialized services, including obstetric and maternity care. In New Mexico, 75% of births are covered by the Medicaid program.

Additionally, SB17 includes an important quality component with 40% of payments tied to measuring and improving outcomes and performance on the following eight agreed-upon metrics:

1. Hospital readmission rates
2. Patient safety and adverse events
3. Screening, Brief Intervention, and Referral to Treatment (behavioral health)
4. Severe sepsis and septic shock
5. Early elective deliveries
6. Patient survey data on communication with doctors
7. Patient survey data on communication with nurses
8. Emergency Department mental health follow-up (behavioral health)

Each eligible hospital will submit to the HCA, upon request, a report demonstrating that the increase in payment for Medicaid-managed care patients provided through the directed payment has enabled it to invest an amount equal to at least 75 percent of its net new funding into the delivery of and access to healthcare services in New Mexico, including (but not limited to) investments in hospital operational costs, workforce recruitment and retention, staff and provider

compensation increases, on-call physician coverage, precepting incentives, creation or expansion of services, community benefit activities, or capital investments**.**

ADMINISTRATIVE IMPLICATIONS

HCA is allowed to use up to 10 percent of the money in the HDAA to administer the Medicaid program for purposes; including 1% for the administration of funds and 9% for underwriting gain and premium taxes.

Section 12 states no later than July 15, 2024, the secretary of health care authority shall seek a waiver, a state plan amendment, or federal authorization as necessary to implement the provisions of the Health Care Delivery and Access Act. The act will become effective on the 1st day of the month after the HCA receives federal and waiver approvals required to implement and administer the Health Care Delivery and Access Act.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP
None.

TECHNICAL ISSUES
None.

OTHER SUBSTANTIVE ISSUES
None.

ALTERNATIVES
None.

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL
Status quo. Rural hospitals in particular will continue to struggle with financial instability.

AMENDMENTS
None suggested.