LFC Requestor: Self Assigned

2024 LEGISLATIVE SESSION
AGENCY BILL ANALYSIS

Section I: General

Chamber: Senate **Category:** Bill
Number: 268 **Type:** Introduced

Date (of **THIS** analysis)**:** 2/2/2024
Sponsor(s): Pete Campos
Short Title: Health Facility Viability Fund

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Section II: Fiscal Impact
APPROPRIATION (dollars in thousands)

Appropriation Contained		**Recurring or Nonrecurring**	**Fund Affected**
FY 24	**FY 25**		
$0	$0	N/A	N/A

REVENUE (dollars in thousands)

Estimated Revenue			**Recurring or Nonrecurring**	**Fund Affected**
FY 24	**FY 25**	**FY 26**		
$0	$0	$0	N/A	N/A

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY 24	**FY 25**	**FY 26**	**3 Year Total Cost**	**Recurring or Non-recurring**	**Fund Affected**
Total	$0	$0	$0	$0	N/A	N/A

Section III: Relationship to other legislation

Duplicates: None

Conflicts with: None

Companion to: None

Relates to: None

Duplicates/Relates to an Appropriation in the General Appropriation Act: None

Section IV: Narrative

1. BILL SUMMARY

a) Synopsis

Senate Bill 268 (SB 268) would create a non-reverting fund in the state treasury to provide financial assistance grants to eligible health facilities that agree to continue, reestablish, or expand their services in a medical underserved area of the state. A single grant may not exceed seven million dollars ($7,000,000), and a single grant period may not extend beyond twelve months.

Grants may be used to subsidize a facility's costs associated with:

- General operations;
- Operational debt;
- Medical malpractice and other insurances;
- Surcharges required pursuant to the Medical Malpractice Act;
- Assessments levied by the state to secure Medicaid matching funds; to the extent permitted by federal law; and
- Other needs and expenses approved by the department

A health facility is eligible to apply for a grant if it:

- Is a licensed public or private general or special hospital, outpatient clinic, crisis triage center or freestanding birth center;
- Is an enrolled Medicaid provider actively serving Medicaid recipients; and
- Is located and operates in a medically under served area of the state.

Is this an amendment or substitution? ☐ Yes ☒ No

Is there an emergency clause? ☐ Yes ☒ No

b) Significant Issues

Rural facilities across the country are often forced to close due to reimbursement frequently failing to cover the cost of care delivery to patients in non-urban areas, a challenge that is even more significant in a hospital's initial years of operation. According to the Center for Healthcare Quality and Payment Reform (The Crisis in Rural Health Care (chqpr.org), more than half of small rural hospitals nationwide that have closed in recent years had losses of 10% or more in the year prior to closure, and over one fourth had losses greater than 20%.

Rural hospitals and health systems make up about 35% of all hospitals across the country and include critical access hospitals (no more than 25 acute care beds and more than 35 miles from the nearest hospital), frontier hospitals (six or fewer residents per square mile) and sole community hospitals (hospitals for Medicare beneficiaries in isolated communities), among other Medicare designations.

Rural hospitals are major economic drivers, supporting one in every 12 rural jobs in the U.S. and contributing $220 billion in economic activity in their communities in 2020. (American Hospital Association: Hospital Closures Threaten Patient Access to Care as Hospitals Face a Range of Rising Pressures: https://www.aha.org/press-releases/2022-09-08-new-aha-report-finds-rural-hospital-closures-threaten-patient-access-care). A variety of factors have contributed to closures, such financial pressures, challenging patient demographics and workforce shortages. Communities served by *critical access hospitals (*CAHs) and other rural hospitals tend to have older, sicker, and poorer populations with access to fewer health care professionals. Rural hospitals make up about 35% of all hospitals in the U.S. Nearly half of rural hospitals have 25 or fewer beds, with just 16% having more than 100 beds.

As a result of patient demographics, reimbursement models, market characteristics, and available services, rural hospitals are closing, and rural communities are losing services in higher proportion than urban communities. Effects of rural hospital closures and reduction of services reduce access to local available healthcare. Rural hospital closures resulted in a rise in emergency medical services costs, increased time and cost of transportation to healthcare services for patients, heightened transportation issues and barriers to care for vulnerable groups, loss of jobs for hospital. (American Hospital Association: Rural Hospital Closures Threaten Access: rural-hospital-closures-threaten-access-report.pdf (aha.org), pages 5-7)

Geographically, New Mexico is a largely rural state. Of New Mexico's 33 counties, seven contain predominantly urban areas defined as part of Metropolitan Statistical Areas (New Mexico Rural Health Plan, page 3: nmhealth.org/publication/view/report/5676/). The remaining 26 Non-Metropolitan counties are considered rural or frontier in nature. It should be noted that there are locations within Metropolitan Statistical Areas counties that are

largely rural or frontier. The very large size of New Mexico counties creates this situation (New Mexico Rural Health Plan: https://www.nmhealth.org/publication/view/report/5676/, page 4).

Rural facilities across the country are often forced to close due to the fact that reimbursement frequently fails to cover the cost of care delivery to patients in non-urban areas, a challenge that is even more significant in a hospital's initial years of operation. According to the Center for Healthcare Quality and Payment Reform (The Crisis in Rural Health Care (chqpr.org), more than half of small rural hospitals nationwide that have closed in recent years had losses of 10% or more in the year prior to closure, and over one fourth had losses greater than 20%.

2. PERFORMANCE IMPLICATIONS

- Does this bill impact the current delivery of NMDOH services or operations?

☐ Yes ☒ No

- Is this proposal related to the NMDOH Strategic Plan? ☐ Yes ☒ No

☒ **Goal 1**: We expand equitable access to services for all New Mexicans
☐ **Goal 2**: We ensure safety in New Mexico healthcare environments
☐ **Goal 3**: We improve health status for all New Mexicans
☐ **Goal 4**: We support each other by promoting an environment of mutual respect, trust, open communication, and needed resources for staff to serve New Mexicans and to grow and reach their professional goals

3. FISCAL IMPLICATIONS

- If there is an appropriation, is it included in the Executive Budget Request?

☒ Yes ☐ No ☐ N/A

- If there is an appropriation, is it included in the LFC Budget Request?

☒ Yes ☐ No ☐ N/A

- Does this bill have a fiscal impact on NMDOH? ☐ Yes ☒ No

4. ADMINISTRATIVE IMPLICATIONS

Will this bill have an administrative impact on NMDOH? ☐ Yes ☒ No

None

5. DUPLICATION, CONFLICT, COMPANIONSHIP OR RELATIONSHIP

None

6. TECHNICAL ISSUES

Are there technical issues with the bill? ☐ Yes ☒ No

7. **LEGAL/REGULATORY ISSUES (OTHER SUBSTANTIVE ISSUES)**

- Will administrative rules need to be updated or new rules written? ☐ Yes ☒ No
- Have there been changes in federal/state/local laws and regulations that make this legislation necessary (or unnecessary)? ☐ Yes ☒ No
- Does this bill conflict with federal grant requirements or associated regulations?

☐ Yes ☒ No

- Are there any legal problems or conflicts with existing laws, regulations, policies, or programs? ☐ Yes ☒ No

8. DISPARITIES ISSUES

New Mexico's health system poses certain challenges for improving the health status of the population as New Mexico's population is not evenly distributed across the state geographically. Of New Mexico's 33 counties, seven contain predominantly urban areas defined as part of Metropolitan Statistical Areas. The remaining 26 Non-Metropolitan counties are considered rural or frontier in nature (New Mexico Rural Health Plan: https://www.nmhealth.org/publication/view/report/5676/, page 3).

Due to current healthcare reimbursement systems, communities with a large proportion of low-income residents and rural communities may not generate sufficient paying demand to assure that providers will practice in these locations (2020-2022 New Mexico State Health Improvement Plan, page 4: nmhealth.org/publication/view/report/5676/). The rural to urban migration of health professionals inevitably leaves poor, rural, and remote areas underserved and disadvantaged. Skilled health professionals are increasingly taking job opportunities in the labor market in high-income areas as the demand for their expertise rises.

The population served would be New Mexico's rural and underserved communities as current and new health professionals could be providing needed health care services. The New Mexico Rural Health Plan (page 53/C-2, https://www.nmhealth.org/publication/view/report/5676/) includes recommendations to support rural health services support statewide.

9. HEALTH IMPACT(S)

Providing health care and public health services in rural areas poses challenges such as the ability to hire and maintain health care providers, and the great distances that many people must travel to get care (New Mexico State Health Improvement Plan, 2020-2022, page 6: https://www.nmhealth.org/publication/view/plan/5311/). The proposed "health facility viability fund" in SB268 could encourage rural health care providers to continue to provide needed health care services in New Mexico's rural areas.

10. ALTERNATIVES

None

11. WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL?

If SB 268 is not enacted, a non-reverting fund in the state treasury to provide financial assistance grants to eligible health facilities that agree to continue, reestablish, or expand their services in a medical underserved area of the state would not be created.

12. **AMENDMENTS**

None