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FISCAL IMPACT REPORT

SPONSOR Sens. Stefanics, Padilla, and Hickey/Reps. Gallegos and Padilla

LAST UPDATED 2/12/24

ORIGINAL DATE 2/2/24

SHORT TITLE Health Care Delivery & Access Act

BILL NUMBER Senate Bill 17

ANALYST Chenier/Graeser

REVENUE*
(dollars in thousands)

Type	FY24	FY25	FY26	FY27	FY28	Recurring or Nonrecurring	Fund
TRD/HCD&A assessments		$79,800.0	$327,300.0	$336,500.0	$346,100.0	Recurring	Health Care Delivery and Access Fund
FMAP		$298,400.0	$1,224,700.0	$1,245,700.0	$1,267,600.0	Recurring	Health Care Delivery and Access Fund
Total Revenue to HCD&AF		**$378,200.0**	**$1,552,000.0**	**$1,582,200.0**	**$1,613,700.0**	Recurring	Health Care Delivery and Access Fund
Reduction for DSH, HVBP & TAP		($28,982.5)	($118,940.0)	($122,280.0)	($125,780.0)	Recurring	Health Care Delivery and Access Fund
Net increase in program funds		**$349,217.5**	**$1,433,060.0**	**$1,459,920.0**	**$1,487,920.0**	Recurring	**Health Care Delivery and Access Fund**
Premiums tax base MCOs			**$1,536,500.0**	**$1,566,400.0**	**$1,597,600.0**		
Additional Premiums Tax MCOs			$46,100.0	$47,000.0	$48,000.0	Recurring	General Fund
Additional Premiums Surtax MCOs			$40,300.0	$41,100.0	$41,900.0	Recurring	General Fund
Additional Premiums Surtax MCOs			$17,300.0	$17,600.0	$18,000.0	Recurring	Healthcare Affordability Fund
Gross Receipts Tax imposed on 40% of this new money			$25,800.0	$26,300.0	$26,800.0	Recurring	General Fund
Local Gross Receipts Tax imposed on 40% of this new money for profit hospitals only			$11,500.0	$11,700.0	$11,900.0	Recurring	Local Governments

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT*
(dollars in thousands)

	FY24	FY25	FY26	FY27	FY28	Recurring or Nonrecurring	Fund
1% for HCA admin		$4,200.0	$17,300.0	$17,580.0	$1,362,140.0	Recurring	HCA operating
HCA underwriting gain		$37,800.0	$67,000.0	$52,500.0	$53,500.0	Recurring	HCA operating
HCA premiums tax			$103,700.0	$105,700.0	$107,900.0	Recurring	HCA operating

HCA/Disbursements Access/Utilization (60% of Total Computable)			$931,200.0	$949,300.0	$968,200.0	Recurring	Health Care Delivery and Access Fund
HCA/Disbursements Quality Incentive (40% of Total Computable)			$620,800.0	$632,900.0	$645,500.0	Recurring	Health Care Delivery and Access Fund

Sources of Information
LFC Files

Agency Analysis Received From
Office of the Superintendent of Insurance (OSI)
Human Services Department/Health Care Authority (HCA)
Taxation and Revenue Department (TRD)

Agency Analysis was Solicited but Not Received From
Department of Health (DOH)

SUMMARY

Synopsis of Senate Bill 17

Senate Bill 17 (SB17) would create the Healthcare Quality Delivery and Access Act to provide for the Healthcare Delivery and Access Medicaid-Directed Payment Program and the healthcare delivery and access fund. The act imposes assessments on most hospitals in the state based on non-Medicare utilization, with the generated funds used for additional reimbursement to hospitals, with the goal of improving and increasing access to healthcare services in the state. The act takes advantage of the multiplier effect of an almost 75 percent Medicaid match (FMAP), with the assessment providing the state's 25 percent share and achieving a $3 revenue impact for every $1 assessment.

All hospitals in the state would be required to report information or data necessary to implement and administer the Healthcare Delivery and Access Act. HCA is permitted to retain 10 percent of assessments to administer the program.

This bill appropriates a calculated amount from the healthcare delivery and access fund to contributing hospitals.

The assessment would be calculated at a rate necessary to cover the Medicaid state share to reimburse hospitals at the average commercial payments rate through directed Medicaid payments. The calculation also includes up to 10 percent in administrative costs. The state Medicaid match amount would come from the delivery and access fund.

The bill also devotes 40 percent of the funding generated by the assessment and matched Medicaid revenue for a newly established quality incentive program. The incentive program would require the authority to establish quality measures and evaluation criteria based on several criteria listed in the bill. Funding not used for quality incentives would be used for uniform rate increases.

Timelines are specified for when the authority is to develop the assessment rates, when hospitals are to pay the assessments, and when the authority will pass funding for the directed payments through the managed care organizations (MCO). The uniform rate increase payments are to begin March 15, 2025, and quality incentive payments on May 15, 2025, unless the federal Centers for Medicare and Medicaid Services (CMS) does not act on the waiver request or requires adjustments to the 50 percent or 10 percent assessment levels.

Other technical changes include applying the assessment to the Tax Administration Act, establishing distributions from the assessments to the delivery and access fund, prohibiting Medicaid managed care organizations from reducing negotiated rates below rates already negotiated when the bill is enacted, requiring the secretary of HCA to seek federal authorization for the rate adjustments, delaying repeal for sections 1 through 11 on July 1, 2030, and establishing a contingent effective date set as the first day of the month subsequent to HCA receiving necessary federal authorizations to implement the act.

This bill contains a contingent effective date and, as a result, would go into on the first day of the month subsequent to HCA receiving the necessary federal authorizations.

FISCAL IMPLICATIONS

The bill does not include a recurring appropriation, but "earmarks" revenue. LFC has concerns with including continuing distribution language in the statutory provisions for funds because earmarking reduces the ability of the Legislature to establish spending priorities.

The intention of the bill is to increase hospital Medicaid payments to the same level as commercial insurance rates. Formally, the assessment is based on provisions that include the following:

- Assessments are based on non-Medicare inpatient days and non-Medicare outpatient gross revenues (billings).
- HCA each year will calculate the assessment percentages or fixed amount per patient day such that the total amount collected in a year, when added to any retained amount from the previous years will be sufficient to bring total reimbursement for Medicaid managed care patients to be equivalent to the average commercial rate plus the costs of managing the program.
- Hospitals in counties with populations of 125 thousand or more as of the most recent decennial census would be considered urban hospitals. Bernalillo, Doña Ana, Sandoval, San Juan and Santa Fe counties would be considered urban, although McKinley County, with a population of 121 thousand in 2020 would be considered rural.
- The University of New Mexico Hospital, Carrie Tingley Hospital outpatient center, UNM Children's hospital and UNM Sandoval Medical Center, New Mexico Behavioral Health Institute in Las Vegas, Miner's Colfax Medical Center in Raton are not included. The 21 federally owned veteran's hospital and community-based outpatient clinics are not required to participate or provide assessments, nor are these government-owned facilities eligible for payments. The Indian Health Service's five hospitals, 11 health centers, and 12 field clinics in the four-state region that includes New Mexico are not liable for assessments or eligible to receive enhanced reimbursement.
- Assessments for a rural hospital or a special hospital are 50 percent of the calculated

amount for urban hospitals.

- Assessments for a small urban hospital (none have been noted) would be reduced by 90 percent from the calculated amount for urban hospitals.
- HCA is authorized to adjust these percentages if necessary to achieve federal approval.

LFC staff have compiled patient day and gross revenue data from several sources:

		Licensed Beds	Staffed Beds	Patient Days	Patient Days per Staffed Bed	Gross Patient Revenue ($1,000)	GPR/Patient Day
Urban Eligible	Bernalillo, Dona Ana, Sandoval, San Juan, Santa Fe	2,528	3,093	591,847	191	$17,119,993	$28,926
Rural Eligible		1,167	1,306	146,726	112	$5,092,482	$34,707
Small Urban Eligible	Santa Fe		12	828	69	$31,559	$38,115
Government		612	777	218,838	282	$2,786,333	$12,732

HCA has used data available to them to create the following forecast:

SB17 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 percent discount and small urban hospitals (two non-Medicaid providers) get a 90 percent discount provided that the assessment with the discounts qualifies for a waiver of the uniformity requirement specified by federal regulations. Ten percent (10 percent) 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 percent 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 percent to the 2024 Base year.

Summary of Hospital Assessment and Funding (Number of Observations: 47 Hospitals)

	BASE	**Implementation Dates**	
Description	**FY24**	**FY25**	**FY26**
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 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.

LFC staff note, however, that this table does not adequately correct for the loss or conversion of three current waiver programs. From data supplied by the Hospital Association, these three programs are estimated as follows:(in millions):

	FY24	FY25	FY26	FY27	FY28
Loss of Disproportionate Share Hospitals	$32.00	$32.83	$33.68	$34.63	$35.62
Conversion of Hospital Value-Based Purchasing Program	$62.00	$63.61	$65.26	$67.09	$69.01
Conversion of Targeted Assessment for Prevention	$19.00	$19.49	$20.00	$20.56	$21.15

LFC has extended the HCA analysis to FY28, used a declining estimate of the federal medical assistance percentage—the federal Medicaid match, or FMAP —and somewhat different annual healthcare inflation estimates.

In addition to these modifications and extensions, LFC has added the impact on insurance premiums and gross receipts taxes. The following table is modeled as close as possible to the HCA table, with the modifications as described above.

	FY24	FY25	FY26	FY27	FY28
IHS-Markit Chained Price index- Consumer Health Care, index 2017=100, BEA	116.0862	119.351225	122.858	126.31195	129.92055
	2.46%	2.60%	2.60%	2.81%	2.86%
	0.7891	0.7891	0.7891	0.7873	0.7855
	3.74	3.74	3.74	3.70	3.66
Summary of Hospital Assessment and Funding (Number of Observations: 47 Hospitals) ($ and bed days in Millions)					
Description	**FY24**	**FY25**	**FY26**	**FY27**	**FY28**
Total Assessment	$345.50	$354.48	$363.70	$373.92	$384.61
Non-Medicare Bed Days	145.39	149.17	153.05	157.35	161.84
Non-Medicare Net Patient Revenue	$200.11	$205.32	$210.65	$216.58	$222.76
Minus: Administrative Cost Allowance	-$34.55	-$35.45	-$36.37	-$37.39	-$38.46
Equal: Available Amount for Directed Payment for Eligible Hospitals	$310.95	$319.04	$327.33	$336.53	$346.15

Total Computable for Eligible Hospitals (with blended FMAP)+Administration	$1,474.40	$1,512.73	$1,552.06	$1,582.19	$1,613.74
State Share	$310.95	$319.04	$327.33	$336.53	$346.15
Federal Financial Participation (FFP)	$1,163.45	$1,193.70	$1,224.73	$1,245.66	$1,267.59
In terms of "new money", we have to subtract three programs for calculating the reimbursements, but not the premiums:					
Loss of Disproportionate Share Hospitals	-$32.00	-$32.83	-$33.68	-$34.63	-$35.62
Conversion of Hospital Value-Based Purchasing Program	-$62.00	-$63.61	-$65.26	-$67.09	-$69.01
Conversion of Targeted Assessment for Prevention	-$19.00	-$19.49	-$20.00	-$20.56	-$21.15
Difference with Current					
Total New Computable for Eligible Hospitals (with blended FMAP)+Administration	$1,361.40	$1,396.80	$1,433.12	$1,459.91	$1,487.96
State Share	$287.12	$294.59	$302.25	$310.52	$319.17
Federal Financial Participation (FFP)	$1,074.28	$1,102.22	$1,130.87	$1,149.39	$1,168.79
Hospital Payment - Access/Utilization (60% of Total Computable)	$884.64	$907.64	$931.24	$949.32	$968.24
Hospital Payment - Quality Assurance (40% of Total Computable)	$589.76	$605.09	$620.82	$632.88	$645.50
Reduction from loss of DSH, VBP &TAP	-$113.00	-$115.93	-$118.94	-$122.28	-$125.78
Total Computable for Administrative Cost	$163.82	$168.08	$172.45	$175.80	$179.30
State Share	$34.55	$35.45	$36.37	$37.39	$38.46
Federal Financial Participation (FFP)	$87.45	$132.63	$136.08	$138.41	$140.84
TOTAL (Directed New Payment for Eligible Hospitals + Administration)	$1,525.22	$1,564.88	$1,605.57	$1,635.71	$1,667.26
State Share	**$345.50**	**$330.03**	**$363.70**	**$373.92**	**$384.61**
Federal Financial Participation (FFP)	**$874.49**	**$1,234.85**	**$1,360.81**	**$1,384.06**	**$1,408.43**
New Premiums Tax Base	$1,459.65	$1,497.60	$1,536.54	$1,566.37	$1,597.60
Gen Fund (3.003%)	$43.83	$44.97	$46.14	$47.04	$47.98
Gen Fund Surtax (3.75%*.7)	$24.63	$39.31	$40.33	$41.12	$41.94
Healthcare Affordability Fund (3.75%*.3)	$30.11	$16.85	$17.29	$17.62	$17.97
Increase in HCA administrative costs	**$16.38**	**$16.81**	**-$17.25**	**$17.58**	**$17.93**
State Share	**$3.46**	**$3.54**	**$3.64**	**$3.74**	**$3.85**
Federal Financial Participation (FFP)	**$8.74**	**$13.26**	**$13.61**	**$13.84**	**$14.08**
Increase in MCO premiums tax	**$147.44**	**$151.27**	**$170.73**	**$158.22**	**$161.37**
State Share	**$31.10**	**$31.90**	**$36.01**	**$33.65**	**$34.61**
Federal Financial Participation (FFP)	**$78.70**	**$119.37**	**$134.72**	**$124.56**	**$126.76**

The additional amount of Medicaid payments, now taxable with a 60 percent deduction and an exemption for nonprofit hospitals for local option gross receipts tax, is included in "Revenue" table at the top of this document. The additional premiums paid to the MCOs, as part of the 9 percent administrative fee retention are shown on two lines of the operating budget impact in table 2.

SIGNIFICANT ISSUES

HCA notes the following significant features of this bill:

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 average commercial rate (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) – To pay for this increase in reimbursement, the hospital assessment program is increasing the tax to 6 percent 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 payments would roll into the new program, essentially sunsetting the HAP 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 go into effect.

OSI notes the following points:

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 SB17, 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 SB17 will result in lower prices charged to privately insured consumers and businesses.

SB17 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 SB17, 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 SB17 will result in lower prices charged to privately insured consumers and businesses.

ADMINISTRATIVE IMPLICATIONS

HCA anticipates using 1 percent of the new revenue plus federal match for administration. The remaining 9 percent will be used to pay underwriting gain and insurance premiums. This may be to reimburse medical care organizations for increased insurance premiums on the increased Medicaid reimbursements.

OTHER SUBSTANTIVE ISSUES

It should be noted that this plan results in increased taxes on all hospital patients in facilities liable for the assessment and eligible for the enhanced reimbursements. The assessments will be hidden from insurance and private pay billings per statute, but billings will increase. Over time, as Medicaid reimbursements increase and make hospitals more solvent, gross billings may decrease because not as much cost-shifting will be necessary. This is a difficult issue to anticipate quantitatively, however.

Attachment:

1. Hospitals Subject to the Assessment

EC/LG/al/hg/ss

Attachment

Hospitals Subject to the Assessment

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