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FISCAL IMPACT REPORT

		LAST UPDATED	
SPONSOR	Tobiassen/Block/Duhigg/Lopez	**ORIGINAL DATE**	2/13/2025
SHORT TITLE	Health Care Authority Market Assessments	**BILL NUMBER**	Senate Bill 297
		ANALYST	Chenier

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT*
(dollars in thousands)

Agency/Program	FY25	FY26	FY27	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Market Assessment	$0.0	$500.0	$0.0	$500.0	Recurring (bi-annual)	General Fund
Market Assessment	$0.0	$500.0	$0.0	$500.0	Recurring (bi-annual)	Federal Funds
Admin 5 FTE	$0.0	$321.0	$321.0	$642.0	Recurring	General Fund
Admin FTE	$0.0	$321.0	$321.0	$642.0	Recurring	Federal Funds
IT systems	$0.0	$50.0	$0.0	$50.0	Nonrecurring	General Fund
IT systems	$0.0	$450.0	$0.0	$450.0	Nonrecurring	Federal Funds
Cost to Set Rates at 200% of Medicare	$0.0	$0.0	$617,000.0	$617,000.0	Recurring	General Funds
Cost to Set Rates at ACR	$0.0	$0.0	Substantial cost but unable to calculate without data	Substantial cost but unable to calculate without data	Recurring	General Funds

Parentheses ( ) indicate expenditure decreases.
*Amounts reflect most recent analysis of this legislation.

Sources of Information

LFC Files

Agency Analysis Received From
Health Care Authority (HCA)

SUMMARY

Synopsis of Senate Bill 297

Senate Bill 297 requires that the Health Care Authority (HCA) conduct a regional assessment of commercial insurance rates for healthcare services covered by the New Mexico Medicaid program. Relative to the regional market assessment, the bill requires New Mexico's Medicaid reimbursements be the greater of 200 percent of the Medicare reimbursement rate for the equivalent service or the regional average commercial insurance reimbursement rate for the service (ACR). The regional market assessments would begin July 1, 2026, and occur every two years thereafter and cover a five-state region, including Arizona, Colorado, Utah, Oklahoma and

Texas. This bill does not contain an effective date and, as a result, would go into effect 90 days after the Legislature adjourns if enacted, or June 20, 2025.

FISCAL IMPLICATIONS

HCA states the bill would have a significant Medicaid recurring fiscal impact on HCA's administrative and program costs. HCA would incur recurring administrative contractual costs for conducting the rate study and program costs for benchmarking the Medicaid reimbursement rates to 200 percent of Medicare rates or the regional average commercial rate (ACR).

In FY25, the general fund cost for increases in Medicaid reimbursement for maternal, behavioral health, and primary care rates from 120 percent to 150 percent of Medicare and to maintain other rates at 100 percent of Medicare was $100 million. The potential additional cost of raising all rates to 200 percent of Medicare is a minimum $2.83 billion or $617 million general fund using a projected financial participation rate of 77.62 percent from FY26 and a medical cost inflation of 2.6 percent. The cost would likely be higher to raise rates to the ACR, but a full ACR analysis is needed to determine the amount. The bill requires HCA to set Medicaid reimbursement at the higher of the two rates.

Hospitals have been excluded from this impact because they receive the ACR through the Healthcare Delivery and Access Act and the nursing facilities are paid through the healthcare quality surcharge (HCQS) and cost rebasing. The bill would also require a significant investment in administrative personnel to monitor providers for compliance with the compensation and hiring requirements.

The bill does not provide an appropriation to HCA to reimburse HCA's costs of implementation. Items that have been reviewed include an estimated $1 million cost of conducting a regional market assessment. HCA would incur staffing costs in overseeing reimbursement practices of "healthcare entities" of $642 thousand based on 5 FTE. HCA would incur costs in making information technology (IT) system changes of approximately $500 thousand, with 90 percent of the costs covered by the federal government.

The total computable administration cost of the bill in FY26 is $2.14 million. The amount of general fund is $871 thousand, and the amount of federal funds is $1.27 million. The estimated costs do not include increased reimbursement costs to providers resulting from changes in provider reimbursement rates.

SIGNIFICANT ISSUES

HCA provides the following:

> NM Medicaid covers many services that do not have a Medicare equivalent and sometimes do not have a commercial equivalent, making the benchmark difficult to apply equitably across service codes. This can result in inflated rates for codes that have a Medicare equivalent while codes that don't remain stagnant.
>
> The bill would require HCA to make significant administrative investments in order to implement rate increases based on the current language. HCA currently lacks the administrative capacity and informational system capability to oversee

how “healthcare entities” use increases in Medicaid reimbursements for direct-patient care.

The current language requires “healthcare entities” who receive increased Medicaid reimbursements from the bi-annual market assessment to use these revenues to compensate health entities who provide direct patient care to Medicaid beneficiaries, i.e. “at least seventy-five percent of the increase in reimbursement revenue be used to: (1) provide increased compensation to healthcare workers and other employees who interact directly with patients; or (2) hire additional healthcare workers and other employees who interact directly with patients.”

For definitional purposes the bill identifies a "healthcare entity" as an entity (other than an individual), that is licensed to provide any form of healthcare in the state, including a hospital, clinic, hospice agency, home health agency, long-term care agency, pharmacy, group medical practice, medical home or any similar entity. Specific entities and concerns are described below.

The definition of “healthcare entities” includes pharmacy, although it is not clear that this bill applies to all aspects of pharmacy (pharmaceutical pricing, dispensing fees, and cognitive services) or just a subset. It should be noted that pricing and payment systems for pharmaceuticals are different than many other services. CMS currently maintains the National Average Drug Acquisition Cost File (NADAC). NADAC currently serves as the state’s pricing modality as well as for Medicare. An interpretation of this bill could potentially lead to doubling the cost of pharmaceutical agents for Medicaid.

A variety of NM Medicaid programs include service codes that do not have a Medicare or commercial equivalent and, as written, would make setting these as the benchmark criteria difficult to apply equitably across service codes. This is the case for the 1115 Home and Community Based Services (HCBS) program called the Community Benefit. In addition, there is currently not a fee schedule in place for Agency-Based Community Benefits, as rates are negotiated between the providers and the Managed Care Organizations.

In the case of home health agency, payment systems are based on an established percentage in relationship to each agency’s cost to charges per unit of services. This methodology is no longer employed by CMS and may not be employed in regional commercial insurances. The discrepancies in reimbursement methodologies would require significant administrative resources to clearly and consistently implement rate adjustments. Additionally, a component of Home Health includes Durable Medical Equipment and Supplies which require multiple instances of manual pricing that are not comparable to CMS nor regional commercial insurances causing opportunities of misalignment with SB297.

PERFORMANCE IMPLICATIONS

HCA provides the following:

It should be noted that health economic factors govern reimbursements in the

direct patient labor market, such as provider shortages, changes in service demand, and managed care contracts with providers. Furthermore, business and commercial practices govern how specific healthcare entities apply reimbursement revenues to meet the needs and wants of service beneficiaries. The bill would apply bi-annual market assessment to inform the reimbursement to healthcare entities. Nonetheless, the successful performance of the bill in meeting its intended purpose depends on health economic factors and business practices.

Beginning July 1, 2026, the bill stipulates HCA review Medicare-equivalent rates and regional ACR market assessment information. The bill specifies using a July 1, 2024, baseline for comparing New Mexico's Medicaid healthcare service reimbursement rates relative to the Medicare-equivalent rates and the regional ACR assessment. The bill also stipulates all "healthcare entities" that receive increases in Medicaid reimbursements (based on the bi-annual market assessment) apply them to their direct patient workforce.

In order to perform the functions described above HCA would need to earmark increased reimbursements to providers and review whether the increased reimbursements are applied as intended in the current language of the bill, i.e. to compensate the direct patient care workforce. The bill does not provide guidance as to steps that would be taken in the event healthcare entities do not apply the reimbursement increases as intended by the bill.

EC/hj/hg