FISCAL IMPACT REPORT

SPONSOR Duncan/Dow/Armstrong **LAST UPDATED** **ORIGINAL DATE** 2/21/2025

SHORT TITLE Medicaid Health Provider Cost Studies **BILL NUMBER** House Bill 400

ANALYST Chenier

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT*

(dollars in thousands)

Agency/Program	FY25	FY26	FY27	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
FTE		$48.7	$48.7	$97.4	Recurring	General Fund
FTE		$48.7	$48.7	$97.4	Recurring	Federal Fund
Contract		$1,250.0	$1,250.0	$2,500.0	Recurring	Federal Funds
Contract		$1,250.0	$1,250.0	$2,500.0	Recurring	General Funds
MAD Program			Up to $2,213,354.0	Up to $2,213,354.0	Recurring	Federal Funds
MAD Program			Up to $617,000	Up to $617,000.0	Recurring	General Funds
Total		$2,597.4	Up to $2,832,951.4	Up to $2,8325,548.8		

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

Relates to appropriations included in House Bill 2

Sources of Information

LFC Files

Agency Analysis Received From
Health Care Authority (HCA)

SUMMARY

Synopsis of House Bill 400

House Bill 400 requires the Health Care Authority to conduct cost studies for every Medicaid-reimbursed health care provider at least once every three years. The bill specifies that these studies must determine the true cost of providing health care services, including compensation for providers and changes in expenses due to inflation or wages. HCA must include a copy of the most recent cost study for each provider type when submitting its budget request to the Legislature. The studies may be scheduled over multiple years, as long as each type of provider is reviewed at least once every three years.

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 provides the following:

The cost of a Medicaid rate study varies significantly depending on the scope of the study, data collection needs, stakeholder involvement, and the consulting firm conducting the study. For example, in FY 2023, Medicaid conducted a comprehensive rate review that cost $1 million; the rate study of home and community-based services for the community benefit program in FY 2024 cost $300 thousand and another rate study for the community-based services for 1915(c) waivers cost $500 thousand. For a rate study with a broad and thorough work scope as required by this bill, estimated cost is $2.5 million per year; this cost is based on conducting a study covering one-third of the providers receiving a Medicaid payment each year as permitted by Section C of the bill by at least two vendors. The cost of the study will get federal match at 50 percent and it will cost the general fund $1.25 million each year.

In addition, the Medicaid program would need additional staff to implement this bill for oversight and collaboration with a vendor for cost-based rate studies. One (1) FTE at pay-band 70 would cost $97.4 thousand with $48.7 thousand in general fund and $48.7 thousand in federal funds.

In addition, the current Medicaid reimbursement rates are benchmarked with the Medicare fee schedule. Medicaid is currently paid between 100 percent to 150 percent of the Medicare rates for equivalent services. In FY25, the general fund cost to pay 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 in general fund. If the rate studies result in reimbursing Medicaid providers an equivalent of 200% of the Medicare rates, excluding hospitals and nursing facilities, it would cost the Medicaid program $2.8 billion with $617 million general fund and $2.213 federal funds. Hospitals have been excluded from this impact as they receive the average commercial rate through the Healthcare Delivery and Access Act and the nursing facilities are paid through the healthcare quality surcharge and cost rebasing.

SIGNIFICANT ISSUES

The Medicaid program has been using the Medicare fee schedule as the benchmark to raise provider reimbursement rates for services that have Medicare equivalence and average rate increase or targeted raise increase for services that Medicare does not cover. The provider reimbursement rate increase is at 100 percent to 150 percent of the Medicare rate based on legislative appropriations for FY 2024 and FY 2025. The requirement of this bill would be a new reimbursement rate setting methodology for health care providers serving the Medicaid population. This new reimbursement methodology will also require a revision to the State Plan and New Mexico Administrative Code. The state plan amendment approval process takes at least six months to obtain approval from the Centers for Medicare and Medicaid Services.

ADMINISTRATIVE IMPLICATIONS

House Bill 395 of the 2023 regular legislative session amended Section 28-16A-16 NMSA 1978 requiring the Department of Health to conduct a biennial independent cost study for recommending reimbursement rates for the 1915(c) waivers – Developmentally Disabled, Medically Fragile, and Mi Via Waivers. The rate study required by House Bill 400 would be duplicative.

Similarly, the Early Childhood Education and Care Department (ECECD) undergoes a separate rate study process for the Family Infant Toddler program. This rate study is funded by ECECD. Any inclusion of these providers in general Medicaid rate studies would be duplicative.

EC/rl/SL2