FISCAL IMPACT REPORT

SPONSOR Campos **LAST UPDATED**
ORIGINAL DATE 2/4/2024
SHORT TITLE Health Facility Viability Fund **BILL NUMBER** Senate Bill 268
ANALYST Chenier

APPROPRIATION*
(dollars in thousands)

FY24	FY25	Recurring or Nonrecurring	Fund Affected
	$70,000.0	Nonrecurring	General Fund

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

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT*
(dollars in thousands)

Agency/Program	FY24	FY25	FY26	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
		$400.0	$400.0	$800.0	Recurring	General Fund

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

Relates to SB161 and SB52.

Sources of Information

LFC Files

Agency Analysis Received From
No Responses Received

SUMMARY

Synopsis of Senate Bill 268

Senate Bill 268 appropriates $70 million from the general fund to the health facility viability fund for financial assistance grants to health facilities. The bill creates the health facility viability fund for the Health Care Authority (HCA) to provide financial assistance grants to health facilities that agree to continue, reestablish, or expand their services in medically underserved areas of the state. The grants can be used to subsidize general operations, operational debt, medical malpractice insurance, surcharges, assessments levied by the state to secure Medicaid matching funds, and other needs and expenses approved by the department. HCA is required to promulgate rules to operationalize the grant program by specifying criteria, grant terms, reporting and auditing requirements, and establishing accountability.

The bill specifies the types of hospitals eligible to apply for the grants. Additionally, the bill requires grantees to submit a solvency plan. HCA is required to grant funds to hospitals in greatest need and to assess that need by considering the facility's financial standing, workforce and service capacities, and the health needs in the facility's service area.

This bill does not contain an effective date and, as a result, would go into effect 90 days after the Legislature adjourns, or May 15, 2024, if enacted.

FISCAL IMPLICATIONS

The appropriation of $70 million contained in this bill is a nonrecurring expense to the general fund. Any unexpended or unencumbered balance remaining at the end of a fiscal year shall not revert to the general fund. Although the bill does not specify future appropriations, establishing a new grant program could create an expectation the program will continue in future fiscal years; therefore, this cost may become recurring.

For a similar bill HCA said that it would take 4 FTE to administer the provisions of that bill and the cost of the 4 FTE would be about $400 thousand.

SIGNIFICANT ISSUES

These facilities provide access to healthcare in remote rural areas of the state where there is limited access to healthcare. The viability of these facilities is dependent on several variables including patient census, and minimum staffing requirements, which can impact operational sustainability. Closure of these facilities would limit access to care and create longer transportation times to access care delaying treatment one to two hours.

The Department of Health provided the following for a similar piece of legislation:

> Rural hospitals and health systems make up about 35 percent 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.
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> 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. A variety of factors have contributed to closures, such as 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 percent of all hospitals in the U.S. Nearly half of rural hospitals have 25 or fewer beds, with just 16 percent having more than 100 beds.
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> 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 result 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, and loss of jobs for hospital.

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. 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.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

Relates to SB161 and SB52 which both make appropriations and create similar funds for similar purposes. SB17 establishes an assessment on hospitals to leverage Medicaid revenue. HB2 contains a special appropriation of $80 million for rural health care providers to expand services that can be billed by Medicaid. This bill's appropriation is limited to health facilities.

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