Financial Support for Rural Hospitals in New Mexico: Actionable Recommendations

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Introduction

In the last several years the State of New Mexico commissioned a number of reports that provide options that the State may want to consider in order to reduce healthcare costs and/or generate additional revenue for in the healthcare system. Two of these reports focus specifically on maximizing revenues to hospitals, rural and otherwise: *Hospital Global Budgets: A Primer and Considerations for New Mexico*, Beth Landon and Associates (2022) and *New Mexico Hospital Global Budgets Report*, Kanneganti, Deepti and Bailit, Michael (2022). Other reports include *Analyses Related to Health Care Cost Drivers in New Mexico: Analysis 1: Feasibility of Implementing a Global Budgeting System* and *An Analysis of Methods to Reduce Administrative Costs in the Health Care System in New Mexico* both written by NORC at the University of Chicago. Additionally, there is a PowerPoint titled *Leveraging Hospital Financial Analyses to Inform State Policy* by Bailit Health and Manatt (2024).

All these reports provide excellent information that the State may want to consider in order to maximize health care financing in New Mexico, and some make rather clear recommendations. However, none of the reports provide information on how, concretely, the State could consider these options, make decisions about which options it wants to pursue and, once determined, how the State can pursue them.

This report endeavors to provide concrete recommendations regarding how the State might consider these options, make decisions about which options to pursue, and how to pursue them with specific regard to funding of the state's rural hospitals. (It should be noted, however, that the structures recommended here could also be used to make other health care planning decisions and determine other health-related initiatives that the State would like to realize and then achieve.)

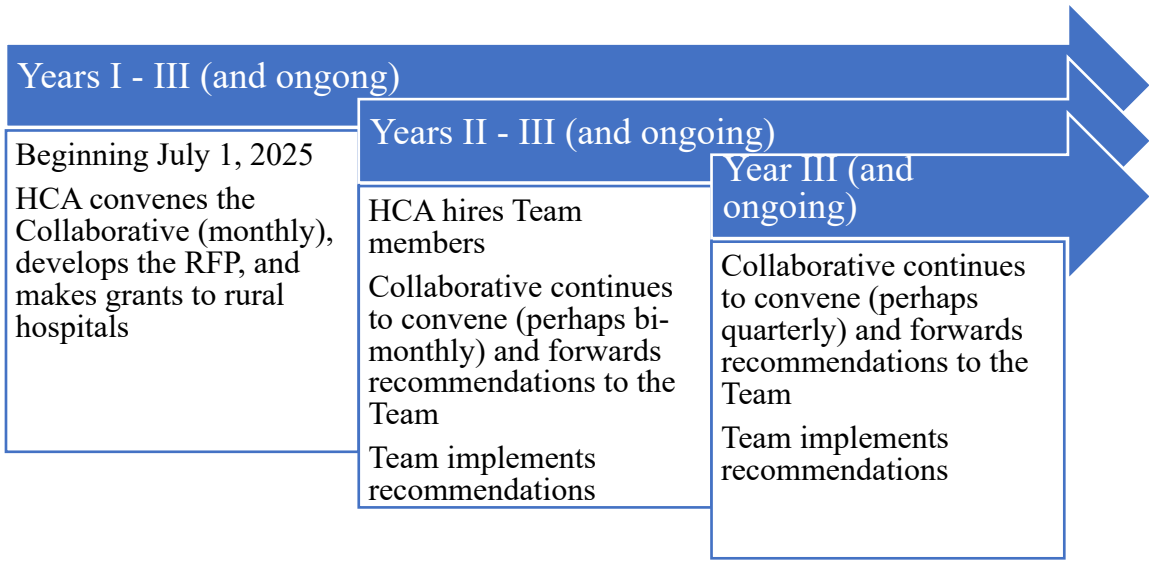
In order to determine and then implement ways of providing ongoing and sustainable funding to New Mexico's rural hospitals, this report provides four concrete, actionable recommendations:

1. Provide stop-gap funding to New Mexico's neediest rural hospitals with the greatest financial challenges for up to three years
2. Develop a "Healthcare Planning Collaborative" to be housed at the Health Care Authority to determine how best to ensure ongoing, sustained support to rural hospitals in New Mexico

3. Develop a Health Collaborative Work Team at the Health Care Authority to operationalize the decisions made by the Collaborative before the stop-gap funding expires
4. Ensure that the Health Care Authority receives adequate, new funding and positions to implement Recommendations 1-3

Overview of and Timeline for these Recommendations

The timeline for these recommendations is three years (and longer if the Collaborative and Team are tasked to address other health related priorities facing New Mexico). In short, it is recommended that funding be provided, through legislative appropriation in July, 2025 to the Health Care Authority to make grants to some of New Mexico's rural hospitals for a period of up to three years (FY26 through FY28). Funds received through these grant awards will provide these hospitals increased financial stability while the Collaborative is created, convened and makes decisions regarding longer term, and sustainable funding decisions for these hospitals (also beginning in FY26). The Collaborative will have roughly one year to develop its vision for ongoing rural hospital funding, and task the Team to realize this vision. The Team will then be hired and have approximately two years (beginning in FY27) to implement the decisions made by the Collaborative, when the legislative appropriation sunsets.



New Mexico's Rural Hospitals

There are multiple definitions of rural. This report uses the Federal Office of Rural Health Policy (FORHP) definition. It is one of the broadest, and most reasonable and, in part, uses the US Census delineation of areas that are not "Metro areas (urban core of 50,000 or more people)".[1]

As such, the following hospitals in the state are considered to be rural:

[1] At: https://www.hrsa.gov/rural-health/about-us/what-is-rural.

- Acoma, Cañoncito Laguna Hospital, San Fidel
- Alta Vista Regional Hospital, Las Vegas
- Artesia General Hospital, Artesia
- Crownpoint Indian Hospital, Crownpoint
- Carlsbad Medical Center, Carlsbad
- Cibola General Hospital, Grants
- Covenant Health Hobbs Hospital/Lea Regional Hospital, Hobbs
- Dan C. Trigg Memorial Hospital, Tucumcari
- Eastern New Mexico Medical Center, Roswell
- Espanola Hospital, Espanola
- Gallup Indian Medical Center, Gallup
- Gerald Champion Regional Medical Center, Alamogordo
- Gila Regional Medical Center, Silver City
- Guadalupe County Hospital, Santa Rosa
- Holy Cross Hospital, Taos
- Lincoln County Medical Center, Ruidoso
- Los Alamos Medical Center, Los Alamos
- Lovelace Regional Hospital Roswell, Roswell
- Mescalero Indian Hospital, Mescalero
- Mimbres Memorial Hospital, Deming
- Miners Colfax Hospital, Raton
- Nor Lea Hospital, Lovington
- Northern Navajo Medical Center, Shiprock
- Plains Regional Medical Center, Clovis
- Rehobeth McKinley Christian Hospital, Gallup
- Roosevelt General Hospital, Portales
- Sierra Vista Hospital, Truth or Consequences
- Socorro General Hospital, Socorro
- Union County General Hospital, Clayton
- Zuni Comprehensive Health Center/USPHS Hospital, Zuni

Stop-Gap Funding to New Mexico's Rural Hospitals

Determining which rural hospitals should be considered for stop-gap funding

I examined the fiscal health of each of the rural hospital listed above using Mathematica data from the NASHP Hospital Cost Tool[2]. These data include information on a hospital's Net Income[3], Net Profit Margin, Fund Balance, Operating Profit (or loss)[4], and Operating Profit

[2] https://www.mathematica.org/dataviz/hospital-cost-tool

[3] "Net Income = Net Patient Revenue – Operating Expenses +/- other income and expenses such as government or research grants, additional public funding, investment earnings (losses), rent revenue from hospital spaces and donations, gifts, and revenues from cafeteria, parking etc." At: https://tool.nashp.org.

[4] "Operating Profit (or Loss) = Net Patient Revenue (Revenue received for hospital patient care, after accounting for certain discounts and allowances and deductions) – Hospital Operating Costs. At: https://tool.nashp.org.

Margin (or loss), from FY11 through FY 2022, the last year for which there are data[5]. It also provides the amount of Covid-19 PHE funding hospitals received in FY20 through FY22. Note, however, that the only data available for Indian Health Services (IHS) hospitals at this site is Fund Balance.

An analysis of these data shows a significant variation in the fiscal wellbeing of New Mexico's rural hospitals. To determine the fiscal wellbeing of each hospital, I examined each hospital's Net Income, Net Profit Margin, Fund Balance, Operating Profit (or loss), and Operating Profit Margin (or loss) and any Covid-19 PHE funding each received.

The chart below shows the high and low for each of these items for each hospital, excluding IHS hospitals for which there are only limited data.

[5] Note that some hospitals may be missing some data.

Hospital	Net Income High	FY	Net Income Low	FY	Profit Margin High	FY	Profit Margin Low	FY	Fund Balance High	FY	Fund Balance Low	FY	Operating Profit High	FY	Operating Profit Low	FY
Acoma, Canoncito Laguna Hospital, San Fidel									$ (12,000,355)	22	$ (34,495,287)	20				
Alta Vista Regional Hospital, Las Vegas	$ 12,715,928	17	$ (6,086,356)	22	30%	17	-22%	22	$ 89,817,616	15	$ (6,366,434)	22	$ 20,470,424	17	$ (2,576,308)	22
Artesia General Hospital, Artesia	$ 9,446,047	15	$ (2,915,681)	22	17%	15	-5%	22	$ 62,688,825	21	$ 17,163,158	11	$ 22,047,835	15	$ 450,070	11
Crownpoint Indian Hospital, Crownpoint									$ (42,671,501)	13	$ (69,263,461)	21				
Carlsbad Medical Center, Carlsbad	$ 36,145,943	13	$ 15,720,748	20	34%	17	18%	20	$ 469,097,403	22	$ 107,390,593	11	$ 72,193,055	12	$ 27,213,197	21
Cibola General Hospital, Grants	$ 7,307,513	13	$ (2,746,406)	18	24%	11	-10%	18	$ 43,114,404	16	$ 22,103,014	11	$ 11,716,484	13	$ (5,970,146)	22
Covenant Health Hobbs Hospital/Lea Regional Hospital, Hobbs	$ 23,219,646	21	$ (6,257,880)	22	104%	21	-14%	22	$ 173,690,499	20	$ (7,809,238)	22	$47,739,807	11	$ (13,113,479)	22
Dan C. Trigg Memorial Hospital, Tucumcari	$ 3,133,144	11	$ (5,975,031)	15	18%	11	-45%	15	$ 20,088,941	12	$ 10,776,430	18	$ 5,910,883	17	$ (5,817,121)	16
Eastern New Mexico Medical Center, Roswell	$ 79,693,842	22	$ 8,845,513	13	72%	21	9%	13	$ 910,715,138	22	$ 317,196,755	11	$ 52,490,816	19	$ 23,621.00	21
Espanola Hospital, Espanola	$ 11,359,500	15	$ 2,697,971	11	17%	14	4%	22	$ 185,056,967	22	$ 92,201,302	11	$ 19,979,609	18	$ 6,760,331	20
Gallup Indian Medical Center, Gallup									$ (126,542,366)	13	$ (273,731,862)	21				
Gerald Champion Regional Medical Center, Alamagordo	$ 40,732,734	21	$ (22,718,552)	12	23%	16	-26%	12	$ 260,855,216	22	$ 49,105,574	14	$ 62,326,065	18	$ 10,379,682	12
Gila Regional Medical Center, Silver City	$ 7,149,129	22	$ (14,158,836)	20	10%	21	-27%	20	$ 66,329,551	11	$ 25,372,884	12	$ 10,725,533	12	$ (23,390,119)	20
Guadalupe County Hospital, Santa Rosa	$ 12,760,239	12	$ (2,021,380)	11	358%	12	1%	18	$ 25,432,368	22	$ 3,727,296	11	$ 3,435,239	18	$ (707,692)	12
Holy Cross Hospital, Taos	$ 6,014,039	22	$ (6,993,697)	14	8%	22	-21%	14	$ 35,562,847	11	$ 17,224,332	18	$ 10,484,734	20	$ (10,697,288)	13
Lincoln County Medical Center, Ruidoso	$ 10,966,604	21	$ (331,714)	13	17%	21	-1%	13	$ 58,834,000	22	$ (33,413,323)	18	$ 15,437,336	20	$ 5,444,013	13
Los Alamos Medical Center, Los Alamos	$ 13,519,679	16	$ 3,697,753	22	21%	16	7%	22	$ 231,897,722	12	$ 68,342,001	11	$ 32,350,449	16	$ 18,394,466	22
Lovelace Regional Hospital Roswell, Roswell	$ 9,167,008	21	$ (1,323,003)	13	15%	14	-3%	13	$ 29,359,784	22	$ (326,194)	13	$ 14,487,281	14	$ 6,669,814	19
Mescalero Indian Hospital, Mescalero									$ (6,923,760)	22	$ (20,381,980)	21				
Mimbres Memorial Hospital, Deming	$ 11,763,952	22	$ 816,983	18	21%	22	2%	18	$ 37,636,062	15	$ 3,236,476	20	$ 13,810,725	22	$ 6,325,858	16
Miners Colfax Hospital, Raton	$ 6,536,820	21	$ (4,430,189)	14	27%	21	-38%	13	$ 27,237,495	12	$ 19,500,870	17	$ 753,966	15	$ (8,512,991)	13
Nor Lea Hospital, Lovington	$ 27,302,577	20	$ 3,981,205	11	25%	20	5%	16	$ 183,088,341	22	$ (98,667,086)	11	$ 33,216,584	20	$ (1,381,720)	17
Northern Navajo Medical Center, Shiprock									$ (131,942,850)	12	$ (252,820,928)	22				
Plains Regional Medical Center, Clovis	$ 30,997,574	21	$ 4,170,310	22	29%	21	4%	22	$ 283,824,868	22	$ (194,141,682)	19	$ 28,907,580	19	$ 8,251,838	20
Rehobeth McKinley Christian Hospital	$ 8,803,154	18	$ (19,588,737)	22	14%	18	-41%	22	$ 12,864,346	11	$ (13,336,115)	22	$ 15,291,186	18	$ (20,192,303)	22
Roosevelt General Hospital, Portales	$ 5,645,487	21	$ (1,354,790)	18	22%	21	-6%	18	$ 22,657,458	21	$ 6,570,058	11	$ 1,623,097	20	$ (4,252,063)	21
Sierra Vista Hospital, Truth or Consequences	$ 5,168,941	20	$ (1,676,578)	17	32%	16	-9%	17	$ 29,030,894	22	$ 7,561,995	11	$ 1,971,564	11	$ (5,061,445)	20
Socorro General Hospital, Socorro	$ 2,307,341	11	$ (3,215,567)	18	9%	11	-13%	18	$ 19,001,607	12	$ (2,296,491)	19	$ 6,572,914	11	$ 1,930,640	21
Union County General Hospital, Clayton	$ 4,174,729	21	$ (2,035,328)	18	42%	21	-27%	18	$ 12,499,453	21	$ 5,471,727	11	$ 4,031,517	12	$ (2,596,013)	22
Zuni Comprehensive Health Center/USPHS Hospital, Zuni									$ (28,848,502)	15	$ (64,585,391)					

Indicates IHS hospital

I do not trust this number. Fund balences for all other years are positive and range from $27,871,681 (FY11) to $58,834,000 (FY22) with a positive trend.

Data missing for FY18 and FY21

Data missing for FY11

The number of years that each hospital experienced 1) a Net Income loss, 2) a Negative Operating Profit, 3) and/or a negative Fund Balance was then quantified. There is a significant variance between the hospitals. For example, some hospitals had no years of Net Income loss, negative Operating Profit, or a negative Fund Balance. These include Carlsbad Medical Center, Eastern New Mexico Medical Center, Espanola Hospital, Los Alamos Medical Center, and Mimbres Memorial Hospital (First Group).

Data for 11 other hospitals is less encouraging. Alta Vista Regional Hospital, Cibola General Hospital, Dan C. Trigg Memorial Hospital, Gila Regional Medical Center, Guadalupe County Hospital, Holy Cross Hospital, Miners Colfax Hospital, Rehobeth McKinley Christian Hospital, Roosevelt General Hospital, Sierra Vista Hospital, and Union County General Hospital all had quite a few negative years as measured by these indicators (Second Group).

Lastly, there is a third set of hospitals that are somewhere in the middle. These include Artesia General Hospital, Covenant Health Hobbs Hospital/Lea County Regional Hospital, Gerald Champion Regional Medical Center, Lincoln County Medical Center, Lovelace Regional Hospital Roswell, Nor Lea Hospital, Plains Regional Medical Center, and Socorro General Hospital (third Group).

The chart below provides the number of years each hospital experienced fiscal hardship as measured against these indicators. I have colored coded each hospital into one of two groups. Green represents the first group of hospitals listed above but also includes Artesia General Hospital, Gerald Champion Regional Medical Center and Lincoln County Medical Center. Red indicates the second group of hospitals listed above but also includes Socorro General Hospital. Note that the IHS hospitals are not color coded because, as indicated before, Mathematica only provides Fund Balance data for these hospitals and other data is not publicly available. I will briefly discuss these IHS hospitals later in this report.

Hospital	Number of Years with Income Loss	Number of Years with Profit Margin in the Negative	Number of Years with a Negative Fund Balance	Number of Years with an Operating Loss
Alta Vista Regional Hospital, Las Vegas	3*	3*	2	3*
Artesia General Hospital, Artesia	3	2	0	0
Carlsbad Medical Center, Carlsbad	0	0	0	0
Cibola General Hospital, Grants	5	5	0	3
Covenant Health Hobbs Hospital/Lea Regional Hospital, Hobbs	2*	1	1	2
Dan C. Trigg Memorial Hospital, Tucumcari	7	7	0	2
Eastern New Mexico Medical Center, Roswell	0	0	0	0
Espanola Hospital, Espanola	0	0	0	0
Gerald Champion Regional Medical Center, Alamagordo	3*	3*	0	0
Gila Regional Medical Center, Silver City	6	6	4	4
Guadalupe County Hospital, Santa Rosa	2*	1	0	3
Holy Cross Hospital, Taos	8	7	0	4
Lincoln County Medical Center, Ruidoso	1	1	1**	0
Los Alamos Medical Center, Los Alamos	0	0	0	0
Lovelace Regional Hospital Roswell, Roswell	2	2*	2*	0
Mimbres Memorial Hospital, Deming	0	0	0	0
Miners Colfax Hospital, Raton	10*	9*	0	9
Nor Lea Hospital, Lovington	0	0	2	3
Plains Regional Medical Center, Clovis	0	0	2	0
Rehobeth McKinley Christian Hospital	8	8	6	6
Roosevelt General Hospital, Portales	3*	2*	0	9
Sierra Vista Hospital, Truth or Consequences	3	3	1	0
Socorro General Hospital, Socorro	7*	8*	1	0
Union County General Hospital, Clayton	4*	4*	0	6

I do not include data for the IHS hospitals here as the only publically available financial data is Fund Balance.

* Indicates that I have coontroled for Covid-19 PHE funding, subtracting it from the amount of money, for that hospital, on that indicator, for the year(s) in which the PHE funding was received and, without which the Hospital would have been in the negative.

**Data shows a Fund Balance of $-33,413,323 in FY18, but a Fund Balance of between $27,871681 (FY11) and $58,834,000 (FY22) in all other years. I do. Not entirely trust this number.

These groupings are significant. My proposal treats the hospitals in each of these two groups differently. Another analysis and rationale for dividing the hospitals in this manor is based on

the information in the charts above and some additional information specific to some of the hospitals.
The following chart shows the average of each hospital's Operating Profit (or loss) and Fund Balance from FY11 through FY22. This was performed to gauge the general recurring health of each hospital and the differences between the green and red groups.

Hospital	Number of Years with an Operating Loss	Average Operating Profit Margin (FY11-FY22)
Alta Vista Regional Hospital, Las Vegas	3*	$9,958,421
Artesia General Hospital, Artesia	0	$11,966,586
Carlsbad Medical Center, Carlsbad	0	$43,825,265
Cibola General Hospital, Grants	3	$3,740,337
Covenant Health Hobbs Hospital/Lea Regional Hospital, Hobbs	2	$19,008,203
Dan C. Trigg Memorial Hospital, Tucumcari	2	$1,225,049
Eastern New Mexico Medical Center, Roswell	0	$41,846,392
Espanola Hospital, Espanola	0	$41,846,392
Gerald Champion Regional Medical Center, Alamagordo	0	$39,562,319
Gila Regional Medical Center, Silver City	4	-$350,012
Guadalupe County Hospital, Santa Rosa	3	$1,096,573
Holy Cross Hospital, Taos	4	$1,692,864
Lincoln County Medical Center, Ruidoso	0	$10,552,356
Los Alamos Medical Center, Los Alamos	0	$24,678,736
Lovelace Regional Hospital, Roswell	0	$9,784,756
Mimbres Memorial Hospital, Deming	0	$9,173,964
Miners Colfax Hospital, Raton	9	-$3,250,061
Nor Lea Hospital, Lovington	3	$11,463,026
Plains Regional Medical Center, Clovis	0	$18,063,696
Rehobath McKinley Christian Hospital	6	$959,296
Roosevelt General Hospital, Portales	9	-$104,558
Sierra Vista Hospital, Truth or Consequences	0	-$1,416,144
Socorro General Hospital, Socorro	0	$3,988,294
Union County General Hospital, Clayton	6	$112,048

Further rationale for placing some hospitals in either the "green" or the "red" group

Nor Lea Hospital[6] had only 3 years of Operating Profit losses but otherwise was in the positive. They had an Operating Profit loss of $-937,360 or -3% in FY11, $-51,671 or 0% in FY12, and $-1,381,720 or -2% in FY17. They had 2 years with a Negative Fund Balance. In FY18 they had a Fund Balance of $-73,885,263 and in FY21 they had a Fund Balance of $-98,667,086. In all other years between FY11 and FY22 (not including FY18 and FY21, years for which the data are missing) they had Operating Profits of between $7,191,195 or 15% (FY13) and $33,216585 or 30% (FY20). They had positive Fund Balances of between 46,826,371 in FY11 and $183,088,341 in FY22. They had no years with a negative Income or a negative Net Profit Margin. These ranged from $3,584,265 or 5% in FY17 to $27,302,577 or 14% in FY20. As such I recommend that they be in the "green" group.

Plains Regional Medical Center had negative Fund Balances of $-194,141,682 in FY19 and $-173,642,501 in FY20 but otherwise positive Fund Balances from FY11 to FY22 of between $148,051,771 (FY11) and $283,824,868 (FY22). They had no years with a negative Net Income, Net Profit Margin, Operating Profit or Operating Profit Margin. Given this, I recommend that they be in the" green" group.

Gerald Champion Regional Medical Center did experience 3 years with Net Income losses and negative Net Margins (FY12, FY13 and FY14) at $-22,718,552 or -26%, $-18,585,186 or -21% and $-4,006,724 or -4% respectively). However, they have shown a positive Fund Balance of between $49,105,574 (FY14) and $260,855,216 (FY22). They have also shown positive Operating Profits of between $10,379,682 or 12% (FY12) and $62,326,065 or 37% (FY18) from FY11 through FY22. As such, I recommend they be in the "green" group.

Lovelace Regional Hospital in Roswell showed a Net Income loss of $-443,594 or -1% in FY11 and a loss of $-1,323,003 or -3% in FY12. However, they were profitable every year between FY11 and FY22 with Operating Profits ranging $6,714,496 or 18% in FY11 to $14,487,281 or 32% in FY13. Additionally, they only had 2 years with a negative Fund Balance. In FY13 they had a Fund Balance of $-326,194 and in FY15 they had a Fund Balance of $-53,290. Otherwise, their Fund Balance has ranged from $193,783 in FY11 to $29,359,784 in FY22, trending up over time with the exception of the 2 negative years. As such, I am considering them financially stable and recommend that they be in the "green" group.

Mimbres Memorial Hospital is a bit of an outlier in the "green" group with an average Operating Budget of $9,173,964 and an average Fund Balance of $24,869,375, two of the lowest in this group. However, they are included in this group as their Operating Profits and Profit Margins have been positive each year from FY12[7] through FY22. Their Operating Profit ranged from $6,325,858 or 21% in FY17 to $10,778,066 or 29%. Additionally, they have no years with a negative Fund Balance or Net Income loss.

The data for **Lincoln County Medical Center** shows a negative Fund Balance of $-33,413,323 in FY18, but a positive Fund Balance of between $27,871681 in FY11 and $58,834,000 in FY22

[6] Data for Net Income, Net Profit Margin, Operating Profit, and Operating Profit Margin is missing for FY18 and FY21.

[7] Data for Mimbres Memorial Hospital for FY11 is missing.

for all other years. The $-33,413,324 may be a reporting error as it is anomalous. However, even if it is correct, they have remained fiscally sound otherwise in all other years, so I recommend that they be in the "green" group.

Covenant Health Hobbs Hospital/Lea County Regional Hospital experienced an Operating Loss in 2 years during the Covid-19 pandemic. In FY21 their Operating Loss was $-950,302 or --4% and in FY22 it was $-13,113,479 or -30%. In all other years they experienced an Operating Profit of between $2,358,885 or 5% in FY19 and $47,739,807 or 55% in FY11. They also experienced a negative Net Income of $-6,257,880 or -14% in FY22 and would have experienced a minimal loss in FY20 if it weren't for Covid PHE funds. They also experienced, for the first time, a negative Fund Balance of -$7,809,238, in FY22. From FY11 to FY22, with these exceptions, they have been profitable showing Net Income of between $96,076 or 0% in FY19 and $23,219,646 or 104% in FY21 and Fund Balances ranging from $29,901,659 in FY21 to $173,690,499 in FY20. As such, and assuming they have returned to pre-Covid profitability, I recommend that they be in the "green" group.

The data for **Socorro General Hospital** is a bit strange, showing 7 years of Net Income and Net Profit losses and 1 year with a negative Fund Balance. However, they show positive Operating Profits and Profit Margins in each year. Given the 7 years of Net Profit losses, I am recommending that they be included in the "red" group.

This is also true for **Artesia General Hospital**. Artesia General Hospital shows an Operating Profit each year from FY11 through FY22 with a range of $450,070 or 2% in FY11 to $22,047,835 or 39% in FY15. However, they show Net Income losses of $-2,487,376 or -4% in FY18, $-1,613,60 or -3% in FY19, and $-2,915,681 or -5% in FY22. They showed positive Net Income in all other years ranging from $2,188,304 or 9% in FY11 to $9,446,047 or 17% in FY15. They have positive Fund Balances in all years ranging from $17,163,158 in FY11 to $62,688,825 in FY21. This is a difficult choice, but I am recommending that they be included in the "green" group.

The remaining hospitals in the "red' group are included because they each have much clearer financial challenges, having relatively significant numbers of years with negative Income losses, and/or Net Profit Margins, and/or Fund Balances, and/or Operating Profits and/or Profit Margins.

New Mexico has six IHS hospitals:

- Acoma, Cañoncito Laguna Hospital
- Crownpoint Indian Center
- Gallup Indian Medical Center
- Mescalero Indian Hospital
- Northern Navajo Medical Center
- Zuni Comprehensive Health Center/ UPSHS Hospital Zuni

These IHS hospitals are determined ineligible for grant funding as they are funded by the federal government and no precedent for New Mexico State Government providing them with State

funding was found. Interestingly, they are funded in a manner that could be considered global budgeting.

Recommendation One: Provision of Stop-Gap Funding to Financially Challenged Rural Hospitals

Based on this analysis, there are 12 "red" rural hospitals that would benefit from additional financial stop-gap support and 12 rural hospitals that appear to be financially stable. Also based on the analysis above, and a determination that these 12 "red" hospitals would benefit from additional financial support, it is recommended that

The $3,000,000 a year recommendation is arrived at as follows: The average dollar amounts for each year in which each "red" hospital's Net Income was a loss for years FY11 through FY22, the years for which there are data, is $-2,664,451. The average Operating Profit (loss) across all "red" hospitals, during the same timeframe, for each year that these hospitals had a negative Operating Profit is $-4,553,687. Given these averages, up to $3,000,000 a year seemed an informed amount.

Given that these analyses are somewhat liberal, erring on the side of including hospitals like Socorro General Hospital in the "red" group, it is recommended that funding be provided to eligible hospitals through a "needs-based" grant application process. The 12 eligible hospitals would be required to submit grant proposals in response to a request for proposals (RFP) that would be developed by the Health Care Authority. In response to the RFP, eligible hospitals would be required to submit a proposal for up to $9,000,000 for three years (up to $3,000,000 a year for each of three years). An important aspect of this process would be the requirement that hospitals applying for these grant funds provide the appropriate financial information to the Health Care Authority (HCA) so that the HCA could ascertain the financial wellbeing of each applicant as part of the grant making process.

In addition to requiring hospitals to demonstrate their financial need, the RFP would require proposals to have 1) a Needs Section that addresses the need for the funding AND the needs to be addressed with that funding, 2) a Grant Narrative or Objectives Section that clearly explains what the money will be used for, 3) a Budget Section, 4) a Budget Narrative Section, and 5) an Evaluation Section for each of the three years for which funding is being requested. Additionally, it is recommended that, at the end of each year, each grantee be required to submit a report to the HCA that demonstrates that the funding has been used successfully to accomplish the goals articulated in their grant proposal. This annual report will be used by the HCA to determine if the grantee can continue with funding and the activities outlined in their original proposal or if changes in funding and/or activities need to be negotiated.

While this funding can assist rural hospitals in numerous ways, based on the specific needs/challenges that a given hospital faces, there is another opportunity here for the State to consider. The Legislature, through its appropriation process, could require each grantee to use some of the funding to address known and/or desired areas of need. For example, some of the authors of the reports listed earlier suggest that funding could be tied to improving linkages with other health providers in the community and/or improving public health/prevention. Other areas

that could be targeted include addressing drug and alcohol addiction, suicide prevention or other health challenges faced by a given community. Alternatively, the HCA could be tasked with determining and requiring which areas of need grantees would be required to address in their grant proposals.

Lastly, I believe that this proposal is informed and defensible. However, the Legislature could choose to address stop-gap funding differently. For example, the Legislature could choose to make stop-gap grant funds available to all non-IHS rural hospitals in the state. While the proposal made above is defensible, political circumstances may suggest other alternatives. Ultimately, however, the goal is to shore up funding to rural hospitals while Recommendations Two, Three, and Four are realized.

Recommendation Two: Develop a "Healthcare Planning Collaborative" to be Housed at the Health Care Authority to Determine how Best to Ensure Ongoing, Sustained Support to Rural Hospitals in New Mexico

Creation of a Healthcare Planning Collaborative

With stop-gap funding in place, the State would then have three years to determine how best to provide sustained and increased funding to rural hospitals. It is recommended that the State use the first of these three years to establish a "Health Care Planning Collaborative".

Just as the State created the Behavioral Health Collaborative in 2004 with the following vision,

> The vision of the Collaborative is to be a single, statewide behavioral health delivery system in which funds are managed effectively and efficiently and to create an environment in which the support of recovery and development of resiliency is expected, mental health is promoted, the adverse affects of substance abuse and mental illness are prevented or reduced, and behavioral health recipients are assisted in participating fully in the lives of their communities.[8]

it is recommended that the State create this Health Care Planning Collaborative with a similar vision and with the first task of developing a plan for providing long term, sustainable funding to New Mexico's rural hospitals. (As indicated above, the State could decide to then use this Collaborative to address other health-related challenges.)

Also, like the Behavioral Health Collaborative, members of this Collaborative would be selected based on their expertise. These members, at a minimum, would include the Secretaries of health- and finance-related State agencies and the Indian Affairs Department. Specifically, and for the purpose of addressing the needs of rural hospitals, it is recommended that the following State agencies provide representatives:

- Health Care Authority (Chair)
- Department of Health
- Aging and Long Term Services Department
- Indian Affairs Department
- Office of the Superintendent of Insurance

[8] At: https://www.hsd.state.nm.us/about_the_department/behavioral-health-collaborative/

- Department of Finance Administration

I would further recommend that representatives from the following organizations/agencies be included for the initial project of determining ongoing and sustainable funding mechanisms for the State's rural hospitals:

- Representatives from at least some of the rural hospitals
- The NM Hospital Association
- Indian Health Services
- The Medical Society
- One of the State's nursing associations

(Once funding to rural hospitals has been addressed, and if the State wishes to task this Collaborative with addressing other health-related challenges, representatives from other relevant State agencies and organizations could be added.)

This Collaborative could also include representation from the State Legislature. For example, members from the following Legislative Committees and the Legislative Finance Committee could be considered:

- The House Health and Human Services Committee
- The Senate Health and Public Affairs Committee

Lastly, this Collaborative may want to invite content experts to assist the Collaborative in understanding and making decisions related to the rather complex solutions it will be considering. For example, these could include one or more of the authors of the papers invoked at the beginning of this report:

- Megan Stead, Charles Betley and/or Elizabeth McOsker from NORC at the University of Chicago with expertise in reducing administrative costs in the health care system and hospital global budgeting
- Miriam Laugesen and/or Michal Gusmano with expertise in a wide range of topics related to hospitals and health care including multi-payer models, fee-for-service models, reducing administrative costs, health care pricing using Medicare fee schedules, uniform utilization review and pre-authorization policies, and more
- Deepti Kannegenti, Michael Bailit at Bailit Health Purchasing, and/or Beth Landon at Beth Landon and Associates with expertise in hospital global budgets
- Someone with expertise with CMS Waivers, specifically 1115 and Innovation Waivers. This expertise exists at the Health Care Authority, but it is listed here as additional individuals with this expertise may be needed
- An individual(s) from a state(s) that has taken this journey successfully and is knowledgeable about the various options, can speak to "lessons learned," and serve as guide and champion throughout this very complex and timely process. In *Hospital Global Budgets: A Primer and Considerations for New Mexico,* Landon and Associates recommends working with the Pennsylvania Rural Hospital Redesign Authority (RHRCA). Janice Winters is their Chief Operating Officer.

It is strongly recommended that, at a minimum, the Health Care Authority, in support of the Health Care Planning Collaborative, contract with someone like Ms. Winters at the Pennsylvania Rural Hospital Redesign Authority[9] [10] to begin with, and then see what, if any, other expertise may be needed based on the direction the Collaborative choses to take.

Note: Just as there will be costs associated with issuing an RFP, reviewing grant proposals, getting funding to grant recipients and reviewing annual progress reports, there will be costs associated with convening and staffing the Health Care Planning Collaborative and contracting with outside experts. As such, discussions with the HCA should occur prior to the submission of legislation to determine if the amount of funding to the HCA that I provide here is adequate.

Areas of Reform that the Health Care Planning Collaborative May Wish to Consider

There are various and numerous options that a state can consider when trying to improve hospital/health care financing, none of which are simple to rollout. Based on the information provided in the reports cited at the beginning of this report and other sources, here is a list of some of the reforms that the Health Care Planning Collaborative might consider:

- **Global Hospital Budgeting**
  "The high-level idea with hospital global budgeting is that a hospital gets paid an agreed-upon amount of revenue each year in advance for all anticipated inpatient and hospital outpatient care. If the model works as intended, hospitals should prioritize prevention and community services because they no longer have an incentive to drive up unnecessary health care use."[11] Global Hospital Budgeting would replace the fee-for-service model currently used in most health care systems and hospitals in the United States. "For financially distressed hospitals, global budgets provide a steady, predictable revenue source that provides necessary access to care."[12] Additionally, this body would need to determine whether only rural hospitals would transition to global hospital budgeting or if all hospitals in New Mexico would. Note that the Centers for Medicare and Medicaid Services (CMS) is ever more supportive of this model and is working with more states to make this transition.[13]
- Relatedly, the Collaborative would need to determine if the State wants to implement an **All-Payer Model**, as have Maryland and Pennsylvania (though these vary) or an **Accountable Care Organization** model as used in Vermont.[14]

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[9] More information on the Pennsylvania Rural Hospital Redesign Center Authority can be found at: https://www.rhrco.org

[10] Other states with similar experience with hospital/healthcare finance reform include Maryland, Vermont

[11] Mathematica at: https://www.mathematica.org/blogs/what-states-can-learn-from-marylands-experience-with-hospital-global-budgeting#:~:text=on%20patients'%20health.-,The%20high%2Dlevel%20idea%20with%20hospital%20global%20budgeting%20is%20that,prioritize%20prevention%20and%20community%20services.

[12] Kanneganti & Bailit (2022) New Mexico Hospital Global Budgets Report. P. 1

[13] Ibid

[14] See Kanneganti & Bailit (2022) New Mexico Hospital Global Budgets Report; No author (2022) Hospital Global Budgets: A Primer and Considerations for New Mexico (A report prepared for the NM Office of the Superintendent of Insurance; Stead & Betley (2023) Analyses Related to Health Care Cost Drivers in New Mexico; Analysis 1: Feasibility of Implementing a Global Budget System

- **Rural Healthcare Tax Credits**
  Recognizing that implementing global hospital budgeting can be a very complex and time-consuming process, the authors of *Analyses Related to Health Care Cost Drivers in New Mexico: Analysis 1: Feasibility of Implementing a Global Budgeting System* provide two alternatives that this body could also consider. Currently, New Mexico offers rural health care tax credits as an incentive to retain providers in rural areas. These authors suggest that this tax credit could be expanded to include a larger group of providers. These authors also suggest that additional funding could be appropriated to the **Rural Health Care Delivery Fund** to support rural hospitals, but clearly this would require agreement from the Legislature and the Governor.

The following areas for potential reform are from *Analyses Related to Health Care Cost Drivers in New Mexico; Analysis 1: Feasibility of Implementing a Global Budget System.*[15]

- **Prior Authorization Standardization**
  The authors recommend that New Mexico reform its prior authorization review process to reduce administrative costs, "ease provider burden, promote clinically sound prior authorizations" and "comply with CMS's proposed rule on interoperability." (pp 13-14) This would reduce administrative costs in the health care system.
- **Standardize Billing Forms and Claims Submission across Payers**
  The authors recommend "developing and implementing an administrative simplification package for claims and billing" (p. 16) that will ease provider burden, increase billing efficiency, reduce claim resubmissions and follow up, and save money.
- **Administrative Simplification**
  The authors recommend "that New Mexico work to align state and quality metrics such as CMS Core Quality Measures…" and "work to appropriately limit the use of additional metrics by payers" (p.15) resulting in a reduced burden on providers and health plans.
- **Standardization of Organizational MCO Contracts**
  The authors recommend "that New Mexico standardized organizational contracts for MCOs, including administrative simplification, standardization and reform of prior authorization, alignment of quality metrics, and submission of data to the State All Payer Claims Database (APCD) and the Health Information Exchange (HIE)." (p. 16) The authors suggest that this will reduce the burden of contract variation.
- **Health Professional Workforce**
  All the reports cited here recognize that one of New Mexico's greatest health care challenges is training, recruiting and retaining health care professionals. This challenge is even more acute in the State's rural areas and disproportionately impacts rural hospitals. The ability to recruit and retain health professionals will greatly reduce the burden faced by these hospitals.
- **Medical Malpractice Reform**
  The authors make three recommendations related to medical malpractice. Two of these require legislative action and are not included here. One, however, could be considered by this Collaborative. The authors recommend that the state "conduct an objective and

[15] Stead & Betley (2023) Analyses Related to Health Care Cost Drivers in New Mexico; Analysis 1: Feasibility of Implementing a Global Budget System. P.13

comprehensive study of the impacts of the State's medical malpractice requirements on hospital budgets and the healthcare workforce." (p. 17). The authors suggest that this would lead to a better understanding of medical malpractice and its impact across the state and on hospitals and could, eventually, reduce the outmigration of health care providers. This body may want to consider contracting with an organization or individual(s) to conduct such a study.

(Note, these authors make a few other recommendations that would require legislative action, one to create a "health strategy and impact council to provide oversight and monitoring of New Mexico's digital infrastructure and cost containment efforts" (p. 20) and through this council, "implement growth caps to mitigate health care cost drivers, including appropriate enforcement mechanisms." (p.22) While these may be informed recommendations and be worth pursuing, these are not as directly related to the more immediate task of shoring up funding to rural hospitals.)

Recommendation 3: Develop a Health Collaborative Work Team at the Health Care Authority to Operationalize the Decisions made by the Collaborative before the Stop-Gap Funding Expires

And

Recommendation 4: Ensure that the Health Care Authority Receives Adequate, New funding to Implement Recommendations 1-3

None of the ideas articulated in the reports that I have cited or suggested in this report will be easy to implement. They will require a team of individuals who are knowledgeable about these issues and who have the time to dedicate themselves to attainment of each of the decisions made by the Health Care Planning Collaborative.

Throughout this process additional staff will be needed at the HCA to write the RFP for rural hospital funding, to make awards to hospitals and to oversee grant funding activities and evaluation over the course of three years. The HCA will also need to convene and facilitate the Collaborative and contract with experts as needed.

Then, as the Health Care Planning Collaborative meets and begins to make decisions, additional staff will be needed to implement these decisions. And these staff will have to have deep knowledge of hospital financing, CMS Waivers, how to facilitate complex change, and how to navigate complex systems with a multitude of players with often competing positions. When it is time to begin thinking about developing this Team, it would be imperative that conversations take place with the Secretary of the Health Care Authority to determine the costs associated with hiring the right people and the need to create the necessary positions at the agency.

In short, conversations with the Health Care Authority regarding creating these new positions and funding these staff and contractor(s) will be essential.

I spoke with Secretary Armijo at the Health Care Authority regarding this report and the recommendations I make in it. Secretary Armijo, while not opposed to the recommendations, did express some trepidation about some of them. The first concern I have mentioned above – that there be adequate funding to the HCA to oversee the grant making process and convene the Collaborative and the Team.

Secretary Armijo also had some concerns about the timing, and possibly the necessity of this proposal. Specifically, she invoked SB161 and SB17 indicating that it is too early to tell if this legislation is or is not adequate to address the financial difficulties faced by some of New Mexico's rural hospitals.

Additionally, she indicated that the HCA is already attending to some of the items that are listed here as items that the Collaborative may want to consider. These include efforts to improve the prior authorization process, streamlining MCO contracts, and standardizing other processes. Given these concerns, I believe that it would be important that a conversation with her take place before moving forward on the recommendations provided in this report.

Conclusion

This report provides concrete, actionable recommendations that, if acted upon, would provide the mechanisms and structures required to determine how best to move forward to provide increased and sustainable funding to New Mexico's rural hospitals and how to operationalize the decisions made by the Collaborative.

Lastly, these structures and mechanisms, if maintained, could also be used to address other health care challenges that New Mexico faces.