LFC Requester:	Eric Chenier

AGENCY BILL ANALYSIS - 2025 REGULAR SESSION

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(Analysis must be uploaded as a PDF)

SECTION I: GENERAL INFORMATION

{Indicate if analysis is on an original bill, amendment, substitute or a correction of a previous bill}

Date Prepared: *2/7/25*
Bill Number: *SB297*

Check all that apply:
Original _x_ Correction __
Amendment __ Substitute __

Sponsor: Sen Tobiassen
Short Title: HCA Market Assessments

Agency Name and Code Number: HCA-630
Person Writing Carlos Ulibarri
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SECTION II: FISCAL IMPACT

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Nonrecurring	Fund Affected
FY25	**FY26**		
$0.0	$0.0	NA	NA

(Parenthesis ( ) indicate expenditure decreases)

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Nonrecurring	Fund Affected
FY25	**FY26**	**FY27**		
$0.0	$0.0	$0.0	NA	NA

(Parenthesis ( ) indicate revenue decreases)

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	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

(Parenthesis ( ) Indicate Expenditure Decreases)

Duplicates/Conflicts with/Companion to/Relates to: Not known
Duplicates/Relates to Appropriation in the General Appropriation Act: Not known

SECTION III: NARRATIVE

BILL SUMMARY

Synopsis: SB297 requires that the Health Care Authority (HCA) conduct a regional assessment of commercial insurance rates for health care 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 (1) 200 percent of the Medicare reimbursement rate for the equivalent service or (2) 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 covering a five-state region, including: Arizona, Colorado, Utah, Oklahoma and Texas.

FISCAL IMPLICATIONS

SB 297 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% of Medicare rates or the regional Average Commercial Rate (ACR).

In FY25, the general fund cost to pay for increases in Medicaid reimbursement for maternal, behavioral health, and primary care rates from 120% to 150% percent of Medicare and to maintain other rates at 100% of Medicare was $100 million in general fund. **The potential additional cost of raising all rates to 200% of Medicare is a minimum $2.83 billion or $617 million general fund** using a projected financial participation rate of 77.62% from FY26 and a medical cost inflation of 2.6%. 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 as 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 (FTEs) 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 implementing the bill. Items that have been reviewed include an estimated cost of conducting a regional market assessment at $1,000,000. HCA would incur staffing costs in overseeing reimbursement practices of "health care entities," $642,000 based on 5 FTE (manager pay-bands). HCA would incur costs in making information technology (IT) system changes of approximately $500,000 with 90% federal funds and 10% state funds.

The total computable administration cost of the bill in FY 2026 is $2,142,000. The amount of General Fund is $871,000 and the amount of Federal Fund is $1,271,000. The estimated costs do not include increased reimbursement costs to providers resulting from changes in provider reimbursement rates.

SIGNIFICANT ISSUES

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 "health care entities" use increases in Medicaid reimbursements for direct-patient care.

The current language requires "health care 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 health care workers and other employees who interact directly with patients; or (2) hire additional health care workers and other employees who interact directly with patients."

For definitional purposes the bill identifies a "health care entity" as an entity (other than an individual), that is licensed to provide any form of health care 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 "health care 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

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 health care 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 health care 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 health care service reimbursement rates relative to the Medicare-equivalent rates and the regional ACR assessment. The bill also stipulates all "health care 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 health care entities do not apply the reimbursement increases as intended by the bill.

ADMINISTRATIVE IMPLICATIONS

The current language would require HCA monitor or perhaps even audit compliance at the provider-level, across specific health care entities receiving reimbursement increases. The information required to confirm a provider's actions to increase work/employee compensation and use of funds to hire additional staff would be an extreme administrative and financial burden to the provider. HCA has implemented a mechanism that required Managed Care Organizations ensure completion of and maintain a copy of a signed provider attestation that funds were used in accordance with a certain policy, however the usage was not auditable therefore not enforceable. No administrative implications for SHB.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

None

TECHNICAL ISSUES

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.

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 is not comparable to CMS nor regional commercial insurances causing misalignment with SB297.

OTHER SUBSTANTIVE ISSUES
The current staffing of skilled personnel needed to perform the administrative functions described in the bill is a significant issue. The bill would require a significant investment by HCA to administer the bill so as to ensure reimbursement increases have their intended purpose, i.e. supporting the direct patient workforce serving Medicaid beneficiaries.

ALTERNATIVES
The New Mexico Medicaid program currently applies a data-driven methodology for reviewing direct patient care reimbursement to health care entities based on claims information. The bill would introduce bi-annual market assessment information to further support this effort, by linking reimbursement changes to Medicare-equivalent caps of 200% or regional ACR information for specific direct patient care services.

Potentially the bill might recognize the use of alternative reimbursement methods for direct patient workforce, as opposed to using regional ACR information or Medicare-equivalent adjustments. An example is given by the use of a value-based purchasing model, adapted from those applied to the reimbursement of hospitals, nursing facilities or primary care practitioners.

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL
Status quo.

AMENDMENTS
None