TITLE 13 INSURANCE
CHAPTER 10 HEALTH INSURANCE
PART 39 PATIENTS' DEBT COLLECTION PROTECTIONS

13.10.39.1 ISSUING AGENCY: Office of Superintendent of Insurance ("OSI").
[13.10.39.1 NMAC - N, 12/28/2021]

13.10.39.2 SCOPE: This rule applies to health care facilities, third-party health care providers, medical creditors, medical debt collectors and medical debt buyers subject to Sections 57-32-1 to 57-32-10 NMSA 1978.
[13.10.39.2 NMAC - N, 12/28/2021]

13.10.39.3 STATUTORY AUTHORITY: Sections 59A-2-9 NMSA 1978 and sections 57-32-1 to 57-32-10 NMSA 1978.
[13.10.39.3 NMAC - N, 12/28/2021]

13.10.39.4 DURATION: Permanent.
[13.10.39.4 NMAC - N, 12/28/2021]

13.10.39.5 EFFECTIVE DATE: December 28, 2021 unless a later date is cited at the end of a section.
[13.10.39.5 NMAC - N, 12/28/2021]

13.10.39.6 OBJECTIVE: To ensure that health care facilities offer and provide screenings to uninsured patients who may be eligible for Medicaid or other public health insurance, and to ensure that medical debt incurred by indigent patients will not be pursued through certain proscribed collection actions.
[13.10.39.6 NMAC - N, 12/28/2021]

13.10.39.7 DEFINITIONS: For definitions of terms contained in this rule, refer to the Patients' Debt Collection Protection Act Sections 57-32-1 to 57-32-10 NMSA 1978 and in Chapter 59A NMSA 1978, unless otherwise noted below.

A. "Culturally and linguistically appropriate" means communication that meets the following requirements:

(1) the provision of oral and hearing-impaired language services (such as the telephone customer assistance hotline) that includes answering questions in any applicable non-English language, including American sign language (ASL), and providing assistance with filing claims and reviews in any applicable non-English language;

(2) the provisions of, upon request, verbal interpretation or translation of a notice into any applicable non-English language;

(3) the inclusion of, in the English version of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the health care facility;

(4) applicable non-English language is as defined by the centers for Medicare and Medicaid Services; and

(5) any written notice required by this rule must include the required information in English and Spanish.

B. "Day" or "days" means, unless otherwise specified:

(1) one – five days excludes weekends and state holidays; and

(2) six days or more includes weekends and holidays.

C. "Deliver" or "delivery means email and retain an email delivery confirmation; written documentation of a verbal communication; electronic transmission through a dedicated two-way communication portal and retain delivery confirmation; fax and retain a fax delivery confirmation; regular mail; or personal delivery. Written documentation may be maintained in a patient's electronic health record.

D. "Disclose" or "disclosure" means the release, transfer, provision of access to, or divulging in any manner of information outside the entity holding the information.

E. "Episode of care" means all emergency or medically necessary health care services related to the treatment of a condition or a service category for such treatment and for acute conditions, includes health care service and treatment provided from the onset of the condition to its resolution or a service category for such treatment and, for chronic conditions, includes health care services and treatment provided over a given period of time.

F. "Federal poverty guidelines" means the poverty guidelines issued annually by the U.S department of health and human services at aspe.hhs.gov/poverty-guidelines/.

G. "Household" means the countable members of the patient's household as defined by modified adjusted gross income.

H. "Medicaid" means the federal health program administered by the New Mexico human services department and established by the federal department of health and human services under Title XIX of the Social Security Act and by state statute, Section 27-1-12 NMSA 1978 et. seq., and regulations, including 8.391.430 NMAC.

I. "Modified adjusted gross income" or "MAGI" means household size and income calculated to determine eligibility for a Medicaid program as set forth by the New Mexico human services department.

J. "Patients' Debt Collection Protection Act" ("the Act") means Sections 1 through 10 of Chapter 57-32 NMSA 1978 and Section 61-18A-2 NMSA 1978.

K. "Public insurance" or "public health insurance" means Medicare, Medicaid, or any other government-supported health insurance and includes insurance offered on the New Mexico insurance exchange or by the New Mexico medical insurance pool.

L. "Screen" or "Screening" means a culturally and linguistically appropriate verbal or written inquiry to the patient about the patient's insured status for purposes of determining presumptive eligibility for Medicaid, eligibility for Medicaid or other public insurance programs, and eligibility for public financial assistance programs, including but not limited to the health care facility's own programs, or county or state indigency assistance.

M. "Uninsured" means that a patient who does not have major medical insurance compliant with the provisions of the Affordable Care Act.

[13.10.39.7 NMAC - N, 12/28/2021]

13.10.39.8 SCREENING FOR INSURANCE AND PROGRAM ELIGIBILITY: A health care facility shall screen all patients and offer to assist uninsured patients in obtaining or accessing Medicaid, public insurance, public programs that assist with health care costs, and other financial assistance offered by the health care facility, before seeking payment for emergency or medically necessary care. A health care facility shall include a written notification regarding screening with any forms presented to patients for completion prior to service. No collection action shall occur during the screening process or while the patient's financial status or application for insurance or financial assistance is under review or in process. During a screening or provision of application assistance under this section, a health care facility shall not request or require information or documentation that is not necessary to determine eligibility for public insurance, public programs that may assist with health care costs, or financial assistance.

A. Timing. Health care facilities shall affirmatively offer to screen patients and, if the patient accepts the offer, screen patients when the patient is registered or within the following time periods:

(a) a patient who is admitted for emergency care shall be screened when the patient's condition has been stabilized through treatment and prior to discharge;

(b) a patient who is admitted for inpatient care shall be screened at the time that the inpatient care is scheduled or within 48 hours of admission;

(c) a patient who receives outpatient care shall be screened at the time that the outpatient care is scheduled or prior to completion of treatment;

(d) upon request of a patient who is scheduled to receive or has received health care services from the health care facility; or

(e) an incapacitated patient, including unconscious or otherwise unable to communicate, shall be screened when the patient is able to effectively communicate, if such status is achieved prior to discharge. The health care facility shall offer screening to parents, spouses, persons with healthcare powers of attorney or guardians of the patient, on the incapacitated patient's behalf.

(f) screening shall be provided upon request and shall be offered at least once for every episode of care within a 12 month period of time;

(g) completion of the screening process may occur outside of the specified time frames if the facility has made a documented good faith effort to complete the screening timely but is unable to do so due to availability of its screening personnel, inability of the patient to provide necessary documentation, or lack of cooperation of the patient.

B. Scope. Screening for public health insurance and health cost assistance eligibility must be offered to every patient and if requested by the patient, the health care facility shall:

(a) verify whether a patient is uninsured;

(b) if the patient is uninsured, offer information about, offer to screen for and screen the patient for:

(i) all available public insurance including Medicaid, Medicare, New Mexico's children's health insurance program and Tricare;

(ii) public programs that may assist with health care costs including but not limited to the New Mexico health insurance exchange, the New Mexico medical insurance pool, county indigent care programs, COVID-19 claims reimbursement programs, and the Indian health service purchased/referred care program; and

(iii) financial assistance offered by the health care facility.

C. Assistance. Health care facilities shall offer to provide assistance to uninsured patients with the application process for programs identified in the screening and, if requested, provide the assistance. Providing assistance means having adequate staff, systems, and equipment available to enable the completion and submission of any Medicaid, financial assistance or other health insurance application(s) within 15 days after receipt from the patient, or his or her representative, of the information necessary to complete the application.

D. Notification. The health care facility must provide notification regarding the screening to patients who are uninsured as follows.

(a) provide information about the insurance for which the patient appears to be eligible and the contact information for the program to which any application was submitted;

(b) the results of the screening must be delivered to the patient, or the patient's legal guardian or parent, if the patient is a minor or disabled, in writing within 15 days of the completion of the screening.

(c) if the patient declines screening, notification must be delivered to the patient with information about how to apply for health insurance, including Medicaid and the New Mexico health insurance exchange within 15 days of the patient's discharge.

(d) if during the screening the health care facility determines that the patient is indigent, the patient must be notified in writing within 30 days of screening, that the medical cost for the health care services may not be the subject of prohibited collection action, although the health care facility may bill the patient for the health services as permitted by law.

(e) if the patient is determined indigent during the screening process the health care facility must take steps to ensure that any subsequent medical debt collection efforts do not include prohibited collection action. Such steps may include notifying the health care facility's billing department and any debt collectors or attorneys acting on behalf of the health care facility; and

(f) if the patient is found presumptively eligible for Medicaid, or eligible for any other public health insurance or financial assistance program, written notification of eligibility must be provided to the patient within 30 days of discharge;

(g) notwithstanding sections (a) through (f) above, notification shall not be required if the patient has not provided a valid telephone number or mailing address or if, after three documented attempts, the facility has been unable to contact the patient.

E. Coordination. If the patient's treatment will include a third-party health care provider who will bill the patient, the information gathered in the screening process will be provided by the health care facility to the third-party health care provider within five business days through a secure method of transmission protecting the confidentiality of the patient's information.

(a) if the patient is uninsured, the third-party health care provider will notify the health care facility that results of the screening must be provided to it, and provide the secure method of transmission for such notification.

(i) the third-party healthcare provider will provide contact information to the health care facility for receipt of screening information.

(ii) the health care facility will provide contact information to all third-party providers with privileges at its health care facility for the purpose of notification of patient screening.

(b) the information transmitted shall include the patient's identifying information, whether the patient participated in the screening, the outcome of the screening and any application process, the status of the patient's application for assistance with health care costs, and whether the screening identified the patient as indigent.

(c) if the health care facility has determined that the patient is indigent and provides that information to the third-party health care provider, neither the health care facility nor the third-party health care provider may engage in prohibited collection action to collect unpaid medical debt.

(d) the third-party health care provider shall not seek payment for emergency or medically necessary care until the health care facility has provided the screening information to the third-party healthcare provider. When the third-party health care provider has received the screening information, it will notify the patient that it has received the results and, if in the process of screening for insurance eligibility it was determined that the patient was found indigent, that it will not pursue any prohibited collection action for the medical costs related to the health care services.

F. Confidentiality. A health care facility or third-party health care provider shall not disclose or use information a patient provides during the screening and application process except as permitted or required in the Act and its implementing regulations and as further provided below:

(a) as needed to facilitate the application process for health insurance or financial assistance as described in Paragraph C of this section;

(b) upon request, a health care facility or third-party health care provider shall disclose information obtained during a screening or application assistance conducted pursuant to this rule or during an indigency determination pursuant to Section 9 of this rule to the patient; or

(c) a health care facility or third-party health care provider is required to disclose information provided during screening or application assistance when required by the human services department or the attorney general's office to investigate or determine the health care facility's or third-party health care provider's compliance with the Act; provided, that such information shall not be used or disclosed by the human services department or attorney general's office for any purpose other than the investigation or determination of the health care facility's or third party health care provider's compliance with the Act.

[13.10.39.8 NMAC - N, 12/28/2021]

13.10.39.9 INDIGENT PATIENT DETERMINATION: Collection action based on charges for health care services and medical debt may not be pursued against an indigent patient. A determination whether a patient is an indigent patient shall be made before collection action is pursued against the patient.

A. Prohibited activity. Medical creditors and medical debt collectors shall not pursue collection action against indigent patients.

(a) A medical creditor may engage in a determination of indigency at the time of service or at any time during or after the provision of services. If the patient is determined to be indigent the medical creditor may not engage in prohibited collection action.

(b) A failure to make a determination of indigency does not waive the prohibition on collection action against indigent patients unless the failure to make the determination is due to noncooperation by the patient. Noncooperation must be documented and the medical creditor or debt collector must be able to demonstrate a minimum of three efforts to contact the patient.

(c) Any bill or statement to a patient must be accompanied by a notice, in English and Spanish, in at least 14-point font in the form prescribed by the superintendent. The superintendent will publish the required notice on its website.

(d) If the patient contacts the medical creditor or medical debt collector to request a determination of indigency, the medical creditor or medical debt collector must make a determination using the methodology set forth below.

B. Methodology. The medical creditor or medical debt collector shall make a determination as to whether the patient is indigent using the following methodology:

(a) household income will be calculated using the methods used to determine Medicaid eligibility by the New Mexico human services department, Title 8 Chapter 200 NMAC, and by the federal Medicaid program utilizing the MAGI protocols promulgated by the New Mexico human services department;

(b) utilizing the most recent federal poverty guidelines, the patient household income and household size, the medical creditor or medical debt collector shall determine whether the patient's income is less than or equal to two hundred percent of the federal poverty guidelines;

(c) in determining household income, the medical creditor or medical debt collector will consider both permanent and temporary income as defined by MAGI;

(d) the inquiry as to indigency is restricted to the categories of income subject to inclusion in the MAGI guidelines;

(e) information obtained from the patient or the patient's household during the determination of indigency shall be considered confidential and may not be used or disclosed for any other purpose; and

(f) the determination of a patient's indigency is valid for 24 months.

C. Indigency tool. The superintendent on an annual basis will provide an optional on-line tool for calculation of indigency for purposes of this section. The superintendent will publish a self-attestation form on its website for use by medical creditors, medical debt collectors and patients in establishing indigency.

D. Use of screening information. If the medical creditor is a health care facility or third-party provider, it may use the information gathered during the screening process to determine whether the patient is indigent. If the patient is indigent based on information gathered during the screening process, then the health care facility or third-party provider shall ensure that its efforts to collect unpaid medical debt do not include prohibited collection action. The health care facility and third-party provider will also inform any medical debt buyer or medical debt collector that collection action is prohibited against that patient**.**

E. Medical creditors. Medical creditors will make the determination of indigency based on verbal or written communication with the patient, in which the patient will be asked to prove household income and household size consistent with the MAGI protocols.

(a) the verbal or written communication will inform the patient that the purpose of the communication is to determine indigency for the purpose of whether collection action may be pursued.

(b) if the patient is a minor or incapacitated, the communication should be with the parent(s), spouse, or legal guardian(s) of the patient;

(c) the verbal or written communication with the patient will be documented, including date, time, identity of person engaged in the communication, and complete contents of the information obtained from the communication; and

(d) the patient may respond to the communication by providing a signed attestation as to household income and size, or through provision of documentation such as pay stubs, at the election of the patient.

F. Notification. The patient will be provided with notification of the results of the determination of indigency in writing within 30 days of the date the medical creditor made the determination but in no event more than 60 days after the determination was initiated.

(a) if the patient is determined to be indigent, the notice shall inform the patient that certain collection action for the health care services and medical debt are prohibited by the Act.

(b) the notice will provide information to the patient about how to apply for Medicaid, public insurance, and insurance through the New Mexico health insurance exchange.

(c) the notice shall inform the patient of the right to complain to the New Mexico attorney general and shall include the website and telephone number of that office.

G. Medical debt collectors. A medical debt collector shall inquire of the medical creditor on behalf of whom it is pursuing collection against a patient, whether that patient had been determined indigent. If the patient has been determined indigent, then certain collection action as defined herein is prohibited.

(a) the action of selling medical debt of an indigent patient to a medical debt buyer or medical debt collector constitutes prohibited collection action.

(b) medical creditors, including but not limited to health care facilities and third-party health providers, shall not hire or otherwise engage third parties to use prohibited collection action or otherwise recover debts from indigent patients. These third parties, including debt collectors and debt buyers, are prohibited from recovering debts from indigent persons, to include activity intended to collect an unpaid medical debt.

[13.10.39.8 NMAC - N, 12/28/2021]

History of 13.10.39 NMAC: [RESERVED]