**TITLE 7 HEALTH**
**CHAPTER 1 GENERAL HEALTH PROVISIONS**
**PART 24 CHARITY CARE DATA REPORTING REQUIREMENTS**

**7.1.24.1 ISSUING AGENCY:** New Mexico Health Policy Commission.
[7.1.24.1 NMAC – Rp, 7 NMAC 1.24.1, 12/31/2000]

**7.1.24.2 SCOPE:** This rule applies to all non-federal health care facilities licensed by the state health facility licensing authority and located in New Mexico.
[7.1.24.2 NMAC – Rp, 7 NMAC 1.24.2, 12/31/2000]

**7.1.24.3 STATUTORY AUTHORITY:** This rule is promulgated pursuant to Sections 24-14A-3(D) and 24-14A-5 of the Health Information Systems Act, Section 24-14A-1 et seq. NMSA 1978.
[7.1.24.3 NMAC – Rp, 7 NMAC 1.24.3, 12/31/2000]

**7.1.24.4 DURATION:** Permanent.
[7.1.24.4 NMAC – Rp, 7 NMAC 1.24.4, 12/31/2000]

**7.1.24.5 EFFECTIVE DATE:** December 31, 2000, unless a later date is cited in the history note at the end of a section.
[7.1.24.5 NMAC – Rp, 7 NMAC 1.24.5, 12/31/2000]

**7.1.24.6 OBJECTIVE:** The purpose of this rule is to specify the reporting requirements related to charity care for non-federal, licensed health care facilities located in New Mexico, pursuant to the Health Information Systems Act, Section 24-14A-1 et seq. NMSA 1978.
[7.1.24.6 NMAC – Rp, 7 NMAC 1.24.6, 12/31/2000]

**7.1.24.7 DEFINITIONS:** In addition to the definitions in the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, the following terms have the following meaning for the purpose of this rule:

**A. Audited FQHC rate** means the 100% total allowable cost per service as determined by the FQHC cost report after audit and finalization by the New Mexico entity legally responsible for administering the Medicaid program (Title XIX of the federal Social Security Act), to be submitted if the facility is certified as a FQHC or FQHC equivalent or receives cost-based reimbursement pursuant to federal law.

**B. Bad debt** means an account receivable based on services furnished to a patient which is: (1) regarded as uncollectible, following reasonable collection efforts, pursuant to the facility's credit and collection policies and procedures; (2) charged as a credit loss pursuant to the facility's credit and collection policies and procedures; and (3) not otherwise classified as charity care.

**C. Charity care** means the provision of medically necessary health care without any expectation of cash inflow and without classification as revenue or receivables in a financial statement, as determined by the criteria established in a formal policy by the facility providing the care.

**D. Charity care charges** means the charges for the provision of health care that is classified as charity care according to the facility's charity care policy. Charity care charges do not include the difference between full charges and allowable amount paid by a third party, including Medicaid, Medicare or the county indigent fund, regardless of a patient's income level.

**E. Charity care encounters** means the total number of patient visits at which charity care was provided in whole or in part.

**F. Charity care policy** means a facility's formal policy that establishes criteria for classifying the provision of medically necessary health care as charity care and includes as a criterion the level of qualifying income as a percentage of the applicable federal poverty level.

**G. Cost to charge ratio** means the relationship that a facility's total operating expenses bear to the facility's reported charges for the same period as determined using total costs and total charges from the federal Health Care Financing Administration Medicare Cost Report.

**H. County indigent fund revenue** means the gross amount received by the facility from a county pursuant to the Indigent Hospital and County Health Care Act, Section 27-5-1 et seq. NMSA 1978, regardless of the purpose, including sole community provider revenue.

**I.** **Director** means the director of the commission.

**J.** **Discharges** means the number of patients with at least one patient day who are formally released from the facility after receiving health care, including patients who die in the facility and excluding newborns and individuals who are dead on arrival.

**K.** **Emergency room charity care inpatient revenue** means the total charity care charges for the following services provided to inpatients: (1) medically necessary care for the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected by a prudent lay person to result in placing the patient's health in jeopardy, impairment to bodily functions or dysfunction of a bodily organ or part; (2) examination or treatment for emergency medical condition or active labor in women or any other service rendered to the extent required by 42 USC 1395(dd); or (3) screening and treatment of patients presenting themselves for unscheduled treatment, in those cases which are ultimately determined not to qualify as an emergency, to the extent that such screening is required by law or is in accordance with accepted standards of medical care.

**L.** **Emergency room charity care outpatient revenue** means the total charity care charges for the following services provided to outpatients: (1) medically necessary care for the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected by a prudent lay person to result in placing the patient's health in jeopardy, impairment to bodily functions or dysfunction of a bodily organ or part; (2) examination or treatment for emergency medical condition or active labor in women or any other service rendered to the extent required by 42 USC 1395(dd); or (3) screening and treatment of patients presenting themselves for unscheduled treatment, in those cases which are ultimately determined not to qualify as an emergency, to the extent that such screening is required by law or is in accordance with accepted standards of medical care.

**M.** **Emergency room encounters** means the total number of patient visits for: (1) medically necessary care for the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected by a prudent lay person to result in placing the patient's health in jeopardy, impairment to bodily functions or dysfunction of a bodily organ or part; (2) examination or treatment for emergency medical condition or active labor in women or any other service rendered to the extent required by 42 USC 1395(dd); or (3) screening and treatment of patients presenting themselves for unscheduled treatment, in those cases which are ultimately determined not to qualify as an emergency, to the extent that such screening is required by law or is in accordance with accepted standards of medical care.

**N.** **Emergency room inpatient revenue** means the total charges for the following services provided to inpatients: (1) medically necessary care for the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected by a prudent lay person to result in placing the patient's health in jeopardy, impairment to bodily functions or dysfunction of a bodily organ or part; (2) examination or treatment for emergency medical condition or active labor in women or any other service rendered to the extent required by 42 USC 1395(dd); or (3) screening and treatment of patients presenting themselves for unscheduled treatment, in those cases which are ultimately determined not to qualify as an emergency, to the extent that such screening is required by law or is in accordance with accepted standards of medical care.

**O.** **Emergency room outpatient revenue** means the total charges for the following services provided to outpatients: (1) medically necessary care for the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected by a prudent lay person to result in placing the patient's health in jeopardy, impairment to bodily functions or dysfunction of a bodily organ or part; (2) examination or treatment for emergency medical condition or active labor in women or any other service rendered to the extent required by 42 USC 1395(dd); or (3) screening and treatment of patients presenting themselves for unscheduled treatment, in those cases which are ultimately determined not to qualify as an emergency, to the extent that such screening is required by law or is in accordance with accepted standards of medical care.

**P.** **Facility control** means the classification for the type of organization that exercises primary control over facility policy and has primary financial responsibility for the operation of the facility. Facility control is reported as of the last day of the reporting period. Facility control is considered vested in the actual operator (i.e. lessee) of the hospital if that entity is different from the owner. Facility control types are: (1) government, including state and local political subdivisions; (2) nongovernment, not-for-profit; and (3) investor owned, for-profit.

**Q.** **Facility ID** means the identification number assigned for internal control to a health care facility licensed by a state health facility licensing authority.

**R.** **Facility license number** means the unique number assigned and listed on the facility's license document issued by the state health facility licensing authority.

**S.** **Federal funds** means all revenues under contracts or grants that the facility received directly from the federal government for the support and provision of medically necessary care to individuals which were not paid on an individual claims basis, including but not limited to those funds appropriated under the Public Health Services Consolidated 330 Act formerly Section 330 Community Health Center, Section 329 Migrant Health Center and Section 340 Homeless.

**T.** **Fiscal year ending** means the last day of the 12-month accounting cycle for which a facility plans the use of its funds.

**U.** **Fund balance or equity** means the residual interest in the assets of an entity that remains after liabilities, also called net assets.

**V.** **FQHC** means federally qualified health center.

**W.** **FQHC rate** means the total allowable cost per service as determined by the Medicaid FQHC cost report, to be submitted if the facility is certified as a FQHC or FQHC equivalent or receives cost-based reimbursement pursuant to federal law.

**X.** **Governmental appropriations** means revenue realized by the facility from state and local taxing authorities, including county indigent fund revenue and sole community provider revenue.

**Y.** **Inpatient** means a patient who is admitted to and lodged in a facility while receiving services.

**Z.** **Medicaid charges** means the total charges attributable to inpatient and outpatient services provided by the facility for participants of the Medicaid or Medicaid presumptive eligibility program billed to Medicaid or a Medicaid contractor and reasonably assumed to be reimbursable under the Medicaid program, excluding Salud and payments from other states.

**AA.** **Medicaid discharges** means the number of patients with at least one patient day who are formally released from the facility after receiving health care and who are participants of the Medicaid or Medicaid presumptive eligibility program, excluding Salud and patients from other states. This number includes patients who die in the facility and excludes newborns and individuals who are dead on arrival.

**BB.** **Medicaid encounters** means the total number of patient visits for medically necessary care attributable to participants of the Medicaid or Medicaid presumptive eligibility program and reasonably assumed to be reimbursable under the Medicaid program, excluding Salud and patients from other states.

**CC.** **Medicaid patient days** means the total number of patient days for patients discharged from the facility attributable to participants of the Medicaid or Medicaid presumptive eligibility program, excluding HMO, organ acquisition, observation bed days, Salud and patients from other states.

**DD.** **Medically necessary care** means a service that is deemed by accepted medical standards of care to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the recipient that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity; including physical, oral and behavioral health services. Medically necessary care does not include: (1) nonmedical services, such as social, educational and vocational services; (2) cosmetic surgery; (3) canceled or missed appointments; or (4) any service for which the facility could not reasonably expect to receive payment from a third party payer.

**EE.** **Medicare charges** means the total charges attributable to inpatient, outpatient and ancillary services provided by the facility for participants of the Medicare program billed to Medicare or a Medicare contractor and reasonably assumed to be reimbursable under the Medicare program.

**FF.** **Medicare discharges** means the number of patients with at least one patient day who are formally released from the facility after receiving health care and who are participants of the Medicare program. This number includes patients who die in the facility and excludes newborns and individuals who are dead on arrival.

**GG.** **Medicare encounters** means the total number of patient visits for medically necessary care attributable to participants of the Medicare program and reasonably expected to be reimbursable by Medicare.

**HH.** **Medicare patient days** means the total number of patient days for patients discharged from the facility attributable to participants of the Medicare program, excluding HMO, organ acquisition or observation bed days.

**II.** **Net Medicaid revenue** means Medicaid charges less provisions for contractual adjustments, excluding Salud and payments from other states.

**JJ.** **Net Medicare revenue** means Medicare charges less provisions for contractual adjustments, including estimated retroactive adjustments.

**KK.** **Net patient revenue** means gross revenue from health care services less provisions for contractual adjustments with third-party payers.

**LL.** **Notice Program Reimbursement** means the letter of notice from the Medicare audit agents containing final adjustments.

**MM.** **Outpatient** means a patient who is not admitted to or lodged in a facility while receiving services.

**NN.** **Patient day** means the unit of measure denoting lodging provided and services rendered to a patient between the census taking hours (usually at midnight) of two successive days. A patient formally admitted who is discharged or dies on the same day is counted as one patient day, regardless of the number of hours the patient occupies a facility bed.

**OO.** **Rural Primary Health Care funds** means all revenues received pursuant to the New Mexico Rural Primary Health Care Act, Section 24-1A-1 et seq. NMSA 1978.

**PP.** **Supplemental Medicaid revenue** means the amount received by a FQHC or FQHC equivalent that represents the difference between the negotiated managed care revenue and FQHC allowable rate.

**QQ.** **Total contractual allowances** means deductions from revenue for the differences between charges at full established rates and negotiated amounts received or to be received from third party payers under contractual agreements.

**RR.** **Total expenses** means the total expenses incurred by the facility during the reporting period.

**SS.** **Total other income** means revenue, gains or losses derived from services other than the provision of health care to patients.

**TT.** **Total patient costs** means all costs incurred in providing patient services and operating the facility.

**UU.** **Total patient encounters** means the total number of visits for medically necessary care.

**VV.** **Total patient revenue** means the total patient charges for medical services provided to patients at the facility before provisions for contractual and other adjustments and revenue forgone for charity care and bad debt.

**WW.** **Total revenue** means the total amount of revenue realized by the facility from all sources, operating and non-operating.

[7.1.24.7 NMAC – Rp, 7 NMAC 1.24.7, 12/31/2000]

**7.1.24.8 REQUIRED SUBMISSIONS:**

**A.** All non-federal health care facilities shall submit the data required by 7.1.24.12 NMAC or 7.1.24.13 NMAC, as applicable, to the commission in accordance with the schedule set forth in 7.1.24.11 NMAC.

**B.** All non-federal health care facilities shall submit their federal Health Care Financing Administration Medicare Cost Report for the same fiscal year as the data required by 7.1.24.12 NMAC or 7.1.24.13 NMAC, as applicable, to the commission in accordance with the schedule set forth in 7.1.24.11 NMAC.

**C.** All non-federal health care facilities shall submit the facility's formal charity care policy or policies to the commission in accordance with the schedule set forth in 7.1.24.11 NMAC. The charity care policy or policies shall include as a criterion the level of qualifying income as a percentage of the applicable federal poverty level.

**D.** All non-federal health care facilities shall submit any Notice Program Reimbursement indicating adjustments that are five percent or greater than costs to the commission within 30 days of the facility's receipt of the Notice Program Reimbursement.

[7.1.24.8 NMAC – N, 12/31/2000]

**7.1.24.9 DATA SOURCE REQUIREMENTS:**

**A**. All data required to be reported by this rule shall be obtained from the facility's most recently filed federal Health Care Financing Administration Medicare Cost Report, to the extent the data is available on that report. If the Medicare Cost Report is the source of the data, the definitions governing the Medicare Cost Report shall supersede any inconsistent definitions in this rule.

**B**. Data required to be reported by this rule that is not available from the facility's most recently filed federal Health Care Financing Administration Medicare Cost Report shall be obtained from the source specified on the reporting form provided by the commission. If the data is not obtained from the specified source, the facility shall report both the required data and its source.

[7.1.24.9 NMAC – N, 12/31/2000]

**7.1.24.10 REPORTING FORMAT:**

**A**. Required data shall be submitted in accordance with the reporting form and instructions provided by the commission. The commission may require facilities to submit the data required to be reported by this rule and other commission rules on one reporting form.

**B.** The commission may specify software or other requirements to promote uniform reporting and efficient analysis. The commission may require that all data be submitted by electronic media (such as computer tape, cartridge or diskette) or by direct electronic transmission.

[7.1.24.10 NMAC – Rp, 7 NMAC 1.24.10, 12/31/2000]

**7.1.24.11 SCHEDULE FOR REPORTING:**

**A.** For fiscal years ending prior to the effective date of this rule: All facilities shall submit the required data according to either the requirements of the initial rule 7 NMAC 1.24, "Charity Care Data Reporting Requirements", sections 8 and 9, effective January 1, 1999 or the requirements of this replacement rule 7.1.24 NMAC, "Charity Care Data Reporting Requirements", effective December 31, 2000.

**B.** For fiscal years ending after the effective date of this rule: All facilities shall submit the required data per this replacement rule 7.1.24.NMAC, effective December 31, 2000, for the facility's prior fiscal year to the commission no later than six months after the end of the prior fiscal year.

[7.1.24.11 NMAC – Rp, 7 NMAC 1.24.8.1, 7 NMAC 1.24.9.1, 12/31/2000]

**7.1.24.12 DATA REPORTING BY LICENSED NONFEDERAL GENERAL AND SPECIALTY INPATIENT HEALTH CARE FACILITIES:** All licensed non-federal general and specialty inpatient health care facilities in New Mexico shall report to the commission the following data for their prior fiscal year:

**A.** Bad debt

**B.** Charity care charges

**C.** Cost to charge ratio (facilities with special circumstances, such as teaching and transplant costs and charges, shall provide a reconciliation of the cost to charge ratio with a modified ratio reflecting those circumstances)

**D.** County indigent fund revenue (facilities with significant pass-through funds to physicians and others shall report the net amount and provide a reconciliation of the gross and net amounts)

**E.** Emergency room charity care inpatient revenue (required for fiscal years ending on or after 10/31/2001)

**F.** Emergency room charity care outpatient revenue (required for fiscal years ending on or after 10/31/2001)

**G.** Emergency room encounters (required for fiscal years ending on or after (10/31/2001)

**H.** Emergency room inpatient revenue (required for fiscal years ending on or after 10/31/2001)

**I.** Emergency room outpatient revenue (required for fiscal years ending on or after (10/31/2001)

**J.** Facility control

**K.** Facility ID

**L.** Facility license number

**M.** Fiscal year ending

**N.** Fund balance or equity

**O.** Governmental appropriations

**P.** Medicaid charges

**Q.** Medicaid discharges

**R.** Medicaid patient days

**S.** Medicare charges

**T.** Medicare discharges

**U.** Medicare patient days

**V.** Net Medicaid revenue

**W.** Net Medicare revenue

**X.** Net patient revenue

**Y.** Total contractual allowances

**Z.** Total discharges

**AA.** Total expenses
**BB.** Total other income
**CC.** Total patient costs
**DD.** Total patient revenue
**EE.** Total revenue
[7.1.24.12 NMAC – Rp, 7 NMAC 1.24.8.2, 12/31/2000]

**7.1.24.13 DATA REPORTING BY EACH FACILITY LICENSED BY A STATE HEALTH FACILITY LICENSING AUTHORITY AS A "DIAGNOSTIC AND TREATMENT CENTER," "LIMITED DIAGNOSTIC AND TREATMENT CENTER," OR "RURAL HEALTH CLINIC":** All licensed diagnostic and treatment centers, limited diagnostic and treatment centers and rural health clinics or the equivalent shall report to the commission the following data for their prior fiscal year:
**A.** Audited FQHC rate(s)
**B.** Bad debt
**C.** Charity care charges
**D.** Charity care encounters
**E.** County indigent fund revenue (facilities with significant pass-through funds to physicians and others shall report the net amount and provide a reconciliation of the gross and net amounts)
**F.** Facility control
**G.** Facility ID
**H.** Facility license number
**I.** Federal funds
**J.** FQHC rate
**K.** Fund balance or equity
**L.** Governmental appropriations
**M.** Medicaid encounters
**N.** Medicare encounters
**O.** Net Medicaid revenue
**P.** Net Medicare revenue
**Q.** Net patient revenue
**R.** Rural Primary Health Care funds
**S.** Supplemental Medicaid revenue
**T.** Total contractual allowances
**U.** Total expenses
**V.** Total other income
**W.** Total patient costs
**X.** Total patient encounters
**Y.** Total patient revenue
[7.1.24.13 NMAC – Rp, 7 NMAC 1.24.9.2, 12/31/2000]

**7.1.24.14 STATUS AND USE OF DATA:**
**A.** All data and information reported under this rule shall become the property of the commission upon receipt.
**B.** The commission may use the data submitted according to this rule to assist it in carrying out the provisions of the Health Information Systems Act, Section 24-14A-1 et seq. NMSA 1978, which may include performing analysis and calculations to determine additional information.
[7.1.24.14 NMAC – Rp, 7 NMAC 1.24.11, 12/31/2000]

**7.1.24.15 MODIFICATION OR EXEMPTION FROM REPORTING COMPLIANCE:**
**A.** Upon written application to the director, the director may grant a health care facility subject to this rule a temporary modification in reporting requirements or a temporary exemption for up to one year. A modification or exemption shall be granted only when the facility makes a reasonable showing that compliance would require unreasonable costs, would be unduly burdensome given the facility's particular circumstances, or is not feasible due to no fault of the facility. A facility requesting a modification must also make a reasonable showing that it will effectuate the purposes of this rule through alternative means.

**B.** A facility granted a temporary modification in reporting requirements shall report data according to the modification. Upon resumption of the regular reporting requirements the facility shall report data according to the requirements of this rule.

**C.** A facility granted a temporary exemption from reporting is not excused from reporting data for the exempted period. Upon resumption of the regular reporting schedule the facility shall promptly report data for the exempted period.

**D.** The facility may appeal the director's decision to the commission, which shall make a final determination on the application.

[7.1.24.15 NMAC – Rp, 7 NMAC 1.24.12, 12/31/2000]

**7.1.24.16 ACCESS TO DATA:** Data collected pursuant to this rule shall be considered an analytical database in accordance with Access to Health Information System Data and Reports, 7.1.20 NMAC (8/30/1997) and access to such data shall be subject to the provisions of 7.1.20 NMAC or made available upon the expressed written authority of the designated administrator of the facility that submitted the data.

[7.1.24.16 NMAC – Rp, 7 NMAC 1.24.13, 12/31/2000]

**7.1.24.17 PENALTIES FOR RULE VIOLATION:** Failure to comply with any of the reporting requirements in this rule may result in injunctive relief and a civil penalty not to exceed $1,000 per violation, as provided by the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978.

[7.1.24.17 NMAC – Rp, 7 NMAC 1.24.14, 12/31/2000]

**HISTORY of 7.1.24 NMAC:**

**Pre-NMAC History:**

None

**History of the Repealed Material:**

7 NMAC 1.24 Charity Care Data Reporting Requirements – Filed with SRC, 12/11/1998