

NEW MEXICO HEALTH POLICY COMMISSION



SM34

DEFINING UNCOMPENSATED CARE

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THE NEW MEXICO HEALTH POLICY COMMISSION

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Ava J. Lovell, University of New Mexico Health Sciences Center

David Roddy, New Mexico Primary Care Association

Bret Goebel, Bret Goebel Consulting

Beth Beers, Socorro General Hospital

Paul Herzog, Memorial Medical Center

John Johnson, Community Action Agency of Southern New Mexico, Las Cruces

Arturo Gonzales Ph.D., Sangre de Cristo Community Health Partnership

Ken Lucero, Councilman, Pueblo of Zia

Tasia Young, NM Association of Counties

HPC Staff Authors: Kevin McMullan, Elisha Leyba-Tercero

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EXECUTIVE SUMMARY

During the 2007 session of the New Mexico legislature, Senate Memorial 34 (SM 34) was passed. The memorial requested that the Health Policy Commission (HPC) convene a task force comprised of nine members appointed by the legislative leadership. The task force was to include diverse representation from large, small, rural, and urban hospitals throughout the state; federally qualified health centers; community-based primary care clinics; community leaders; and indigent fund representatives of county commissions who set policy for indigent or uncompensated care. In addition, the memorial requested that a member of the house of representatives and a member of the senate from the 2006 interim legislative health and human services committee be appointed by the chair and vice chair of that committee to serve as advisors to the task force. The memorial further requested that the task force and advisors present conclusions, including a working definition of “uncompensated care”, at the November 2007 meeting of the legislative health and human services committee. A complete copy of SM34 is attached in Appendix A.

The SM 34 task force met in October 2007 to define and develop a calculation for “uncompensated care”. After much discussion, the task force determined that in order to define “uncompensated care”, other terms also needed to be defined. These terms included operating costs, gross patient charges, bad debt, charity care, and cost-to-charge ratio. Taking into consideration the Generally Accepted Accounting Principles (GAAP) guidelines, which all entities must utilize for financial statements, the task force defined these terms as follows:

- **Operating Costs - The expenses required to deliver health care including interest, depreciation, amortization and overhead. The operating cost of a health care provider varies by entity and is exclusive of bad debt.**
- **Gross Patient Charges - The non-discounted amounts required to be charged to all patients for care. Charges will vary from entity to entity.**

- **Bad Debt - Accounts that are written off on a gross charge basis for services for which payment was anticipated, but not received. The policy of each entity will determine when an account may be written off. Similar to charity care, bad debt amounts are charges that must be converted to cost for the purpose of determining amounts of uncompensated care.**
- **Charity Care - Sometimes referred to as “indigent care” (not to be confused with “indigent fund”), is health care service provided to patients who are not able to pay for such service. Gross charges for services must be converted to cost for the purpose of determining and reporting the amount of charity care.**
- **Cost-to-Charge Ratio - The ratio of costs to gross charges from audited financial statements. It is total operating costs (exclusive of bad debt at cost) divided by gross patient charges.**

Cost-to-Charge Ratio = total operating costs ÷ gross patient charges

These terms are included in the task force’s definition and calculation of “uncompensated care”:

- **Uncompensated Care – a health care provider’s bad debt and charity care. Uncompensated care is calculated as follows:
Uncompensated Care = (Bad debt + charity care) x cost-to-charge ratio**

NOTE: UNCOMPENSATED CARE IS CALCULATED ON AN ENTITY BY ENTITY BASIS.

The SM 34 task force also discussed issues associated with “indigent care”. The task force agreed that it is important to note that “indigent care” is different from that of county “indigent funds”. Policies set by counties with respect to their indigent funds may not reflect policies set by health care providers with respect to indigent care.

INTRODUCTION

During the 2007 session of the New Mexico legislature, Senate Memorial 34 (SM 34) was passed. The memorial requested that the Health Policy Commission (HPC) convene a task force comprised of nine members appointed by the legislative leadership. The task force was to include diverse representation from large, small, rural, and urban hospitals throughout the state; federally qualified health centers; community-based primary care clinics; community leaders; and indigent fund representatives of county commissions who set policy for indigent or uncompensated care. In addition, the memorial requested that a member of the house of representatives and a member of the senate from the 2006 interim legislative health and human services committee be appointed by the chair and vice chair of that committee to serve as advisors to the task force. The memorial further requested that the task force and advisors present conclusions, including a working definition of “uncompensated care”, at the November 2007 meeting of the legislative health and human services committee. A complete copy of SM34 is attached in Appendix A.

The SM 34 task force included representatives from the University of New Mexico’s Health Sciences Center, the New Mexico Primary Care Association, Bret Goebel Consulting, Socorro General Hospital, Memorial Medical Center, Health Communities Action Agency, Sangre de Cristo Community Health Partnership, Zia Pueblo Council, and the New Mexico Association of Counties. Representatives from other organizations such as the New Mexico Hospital Association and Santa Fe, Lincoln, and Los Alamos Counties were not part of the task force, but participated in the discussions. New Mexico Senator Linda Lopez served as chair and advisor to the task force.

The task force defined and developed a calculation for uncompensated care. This report discusses this uncompensated care definition and calculation as well as additional issues related to uncompensated care. Further, this report provides background information including earlier studies related to uncompensated care.

STUDIES RELATED TO UNCOMPENSATED CARE

There have been various studies addressing the issue of uncompensated care in New Mexico. In 1999, the HPC contracted with the University of New Mexico's Institute for Public Policy to develop a preliminary report, *Public Valuation of Basic Health Care Services in New Mexico*. While this 1999 study was not specifically related to uncompensated care, it addressed issues related to uncompensated care. In 2005, the HPC's House Memorial 43 study, *Report on Hospital Charges, Quality and Charge Increases*, also discussed but did not define uncompensated care.

2006 information from the New Mexico Hospital Association's 2006 Annual Report indicated that hospitals provided \$363,168,324 in uncompensated care.¹ The New Mexico Primary Care Association reports in 2005 that the primary care clinics had \$27.1 million in uncompensated care on a charge basis. The clinics charge to cost ratio was \$1.25 in costs for each dollar in charges due so the actual cost of the uncompensated care was \$36 million. After all payments, grants, and subsidies the clinics reported a system wide loss of \$2.8 million for 2005.² Estimate data does not exist for other providers in the state much less a standard definition of what it means. Uncompensated care is a large and undefined amount in New Mexico.

The importance of reporting uncompensated care was addressed in the 1997 House Joint Memorial 18 (HJM18). The study requested that the HPC adopt uniform definitions and standard measures for uncompensated care.³ The Commission determined that the most feasible method for consistent assessment of charity care and uncompensated care costs should use charges generated for charity care patients adjusted by a cost to charge ratio for each facility. The Commission also determined that the cost of uncompensated care should be adjusted by block payments, grants, contracts, or any other indirect compensation to facilities for charity care and uncompensated care, which should also be reported by the facilities."⁴

AMERICAN HOSPITAL ASSOCIATION (AHA) DEFINITIONS

According to the AHA the term “uncompensated care” is an overall measure of hospital care provided for which no payment was received from the patient or insurer. It is the sum of a hospital's "bad debt" and the charity care it provides. Charity care is care for which hospitals never expected to be reimbursed. A hospital incurs bad debt when it cannot obtain reimbursement for care provided. This happens when patients are unable to pay their bills, but did not apply for charity care, or are unwilling to pay their bills. Uncompensated care excludes other unfunded costs of care, such as underpayment from Medicaid and Medicare.”⁵

According to the AHA, “bad debt consists of services for which hospitals anticipated but did not receive payment. Charity care, in contrast, consists of services for which hospitals neither received, nor expected to receive, payment because they had determined, with the assistance of the patient, the patient’s inability to pay. In practice, however, hospitals have difficulty in distinguishing bad debt from charity care.”⁶

Depending on a variety of factors, including “whether a patient self-identifies as medically indigent or underinsured in a timely manner, care may be classified as either charity care or bad debt. Bad debt is often generated by the medically indigent and uninsured, making the distinctions between the two categories arbitrary at best.”⁷

The AHA states that, “uncompensated care data are sometimes expressed in terms of hospital charges, but charge data can be misleading, particularly when comparisons are being made among types of hospitals, or hospitals with very different payer mixes. For this reason, the AHA data on hospitals’ uncompensated care are expressed in terms of costs. It should be noted that the uncompensated care figures do not include Medicaid or Medicare underpayment costs.”⁸

However, historically and today, hospitals and other health care providers have different financial policies and thus comparing bad debt and free care across hospitals is often confusing. According to AHA, “care delivered to a patient may be classified as charity care by one hospital, but bad debt by another. This does not mean, however,

that care classified as bad debt was provided to patients who can afford to pay. On the contrary, bad debt can be generated by people with limited resources, making the distinctions between the two categories virtually meaningless.”⁹

COUNTY INDIGENT FUNDS

Thirty of the 33 New Mexico counties are annually requested by acute care hospitals in their county or service area to provide funding for uncompensated care. This funding is in the form of payments to hospitals from county indigent funds and intergovernmental transfers from the counties to the state for sole community provider matching payments. The sole community provider program is a federal match/state payment program for hospitals that are the only hospital in a community. In 2006, New Mexico counties collected \$52.9 million for County Indigent Funds primarily through gross receipts taxes.¹⁰ The state as well supplies some state monies annually to the University of New Mexico Hospital in the form of an Out-of-County Indigent Fund appropriation. The 2007 legislature budgeted \$1.241 million for this program.¹¹ Many counties also provide direct payment from the Indigent Funds to hospitals (in addition to their sole community match) for services provided to residents of that county. This includes payment to UNMH and other out-of-county hospitals.

UNCOMPENSATED CARE AS DEFINED BY THE SM 34 TASK FORCE

The SM 34 task force met in October 2007 to define and develop a calculation for “uncompensated care”. After much discussion, the task force determined that in order to define “uncompensated care”, other terms also needed to be defined. These terms included operating costs, gross patient charges, bad debt, charity care, and cost-to-charge ratio. Taking into consideration the Generally Accepted Accounting Principles (GAAP) guidelines, the task force defined these terms as follows:

- **Operating Costs - The expenses required to deliver health care including interest, depreciation, amortization and overhead. The operating cost of a health care provider varies by entity and is exclusive of bad debt.**
- **Gross Patient Charges - The non-discounted amounts required to be charged to all patients for care. Charges will vary from entity to entity.**
- **Bad Debt - Accounts that are written off on a gross charge basis for services for which payment was anticipated, but not received. The policy of each entity will determine when an account may be written off. Similar to charity care, bad debt amounts are charges that must be converted to cost for the purpose of determining amounts of uncompensated.**
- **Charity Care - Sometimes referred to as “indigent care” (not to be confused with “indigent fund”), is health care service provided to patients who are not able to pay for such service. Gross charges for services must be converted to cost for the purpose of determining and reporting the amount of charity care.**
- **Cost-to-Charge Ratio - The ratio of costs to gross charges from audited financial statements. It is total operating costs (exclusive of bad debt at cost) divided by gross patient charges.**

Cost-to-Charge Ratio = total operating costs ÷ gross patient charges

These terms are included in the task force's definition and calculation of "uncompensated care":

- **Uncompensated Care – A health care provider's bad debt and charity care. Uncompensated care is calculated as follows:
Uncompensated Care = (Bad debt + charity care) x cost-to-charge ratio**

Example: A provider has total gross charges for all patients of \$1,000,000 and total operating costs, exclusive of bad debt, of \$500,000. This produces a cost-to-charge ratio of .50 or 50%. A provider charges \$1,000 for services provided to a patient. The uncompensated care cost of this episode is .50 X \$1,000 or \$500.

The New Mexico Hospital Association recommends that "use of a cost-to-charge ratio methodology eliminates concerns about uncompensated care being based on arbitrary setting of prices (charges). Rather, the ratio converts each provider's charges to their actual cost of providing care." The New Mexico Association of Counties recommends this last sentence read "the ratio converts each provider's charges to their actual *estimated* cost of providing care."

Note: Uncompensated care is calculated on an "entity by entity" basis.

It is important to note that the term "indigent care" is often used interchangeably with "charity care" in the health care industry. Indigent or charity care is different from "indigent funds" of counties. Claims made to the indigent funds of counties should be treated as compensated care similar to that of other governmental funds are such as Medicare or Medicaid. As such, those patients accounts paid through a county indigent fund would not be classified as charity or indigent.

Further, under Medicare regulations, services received by a Medicare recipient must be recorded at a standard set of rates (gross charges). This means that the charges that are recorded for a service must be the same for Medicare, Medicaid, insurance, self-pay or charity patients (i.e. room rates). If the standard rate for a provider is \$500 a day,

then all patient bills must show this rate. Another provider may have a \$600 a day rate, but all of that provider's patients' must show that standard \$600 room rate.

ADDITIONAL ISSUES RELATED TO UNCOMPENSATED CARE

Below are additional issues included in the SM 34 task force's discussion of uncompensated care:

1. The possible confusion over charity versus indigent care might require separate definitions. The task force split evenly over this question.
2. Underpayment from any contracted payer sources, such as Medicaid, should not be defined as uncompensated care.
3. Policies set for county "indigent funds" are set by counties, and the providers set their own bad debt and "indigent care" policies.

The New Mexico Hospital Association developed and presented to the task force its own policy statement on uncompensated care (see Appendix B).

4. There is a concern that the Indian Health Service (IHS) is often left out of the discussions on indigent care, and consideration should be given to IHS in any future work. Discussion was held regarding the University of New Mexico Hospital lease agreement with IHS and what the agreement means to indigent care provision in New Mexico and specifically for urban Indian health care.
5. There is a need for a review of state statutes and rules relating to uncompensated care. This would also include the rules and regulations among the counties, including indigent care eligibility rules.
6. Independent physicians were not included as members of the task force, yet they provide large amounts of uncompensated care. Future discussions should include physicians.

7. New Mexico counties requested that the state move towards standardized reporting of uncompensated care in the future which this memorial assists with common definitions.

REFERENCES

1. *2006 Annual Report*, New Mexico Hospital Association.
2. Analysis provided by David Roddy of the New Mexico Primary Care Association, e-mail correspondence of Nov 2, 2007.
3. *House Joint Memorial 18: Uncompensated Care in New Mexico Health Care Facilities*, report of the New Mexico Health Policy Commission, May 1998, page 4.
4. *Ibid.*
5. *American Hospital Association Uncompensated Hospital Care Cost Fact Sheet*, Oct 2007, page 1. Found at <http://www.aha.org/aha/content/2007/pdf/07-uncompensated-care.pdf>.
6. *American Hospital Association Uncompensated Hospital Care Cost Fact Sheet*, Oct 2007, page 2. Found at <http://www.aha.org/aha/content/2007/pdf/07-uncompensated-care.pdf>
7. *Ibid.*
8. *Ibid.*
9. *American Hospital Association Uncompensated Hospital Care Cost Fact Sheet*, Oct 2005, page 2. Found at <http://www.aha.org/aha/content/2005/pdf/0511UncompensatedCareFactSheet.pdf>.
10. *2006 County Financing of Health Care*, New Mexico Health Policy Commission, Jan 2007, page 1. Found at <http://www.hpc.state.nm.us/reports/CFHC/2006-%20EDIT-CFHC%20REPORT.pdf>.
11. *House Bill 2*, 2007 Legislative Session, page 195. Found at <http://legis.state.nm.us/Sessions/07%20Regular/final/HB0002.pdf>.

APPENDIX A

A MEMORIAL REQUESTING A STUDY OF UNCOMPENSATED, INDIGENT AND CHARITY CARE IN NEW MEXICO TO CREATE A SINGLE DEFINITION FROM WHICH POLICYMAKERS MAY REASONABLY MAKE POLICY DECISIONS.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

WHEREAS, state policymakers appropriate funds and make policy each year to address "uncompensated care", or hospital care for which taxpayers must pay because it is not covered by insurance; and

WHEREAS, New Mexico counties provided forty million seven hundred thousand dollars (\$40,700,000) for indigent medical services in fiscal year 2004; and

WHEREAS, various hospitals and other health care providers define "uncompensated care" in various ways, including it as bad debt that will not be collected, as reduction in revenue such as an underpayment from medicaid or medicare, discounts to private payers or other voluntary or involuntary discounts and as charity care or indigent care for purposes of accounting and for purposes of reporting on the hospital's and other health care provider's financial status; and

WHEREAS, uncompensated care is calculated on an individual facility basis and reported according to any definition a hospital or other health care provider may elect to use; and

WHEREAS, uncompensated care has cost the nation approximately twenty-six billion nine hundred million dollars (\$26,900,000,000) in the twenty-five years ending in 2004; and

WHEREAS, no uniform, meaningful definition of uncompensated care is used nationwide or within New Mexico; and

WHEREAS, the appropriation of an adequate sum for uncompensated care is critical in a time, such as this one, when uninsured patients often receive care in the state's hospital emergency rooms, offices and clinics of other providers that request appropriations to offset the cost of providing care to those who cannot or will not pay;

NOW, THEREFORE, BE IT RESOLVED BY THE SENATE OF THE STATE OF NEW MEXICO that the New Mexico health policy commission be requested to convene a task force; and

BE IT FURTHER RESOLVED that the task force comprise nine members appointed by the legislative leadership, including a diverse representation of large and small, rural and urban hospitals from throughout the state, federally qualified health centers and community-based primary care clinics, as well as community leaders and indigent fund representatives of county commissioners who are setting policy for indigent or uncompensated care; and

BE IT FURTHER RESOLVED that a member of the house of representatives and a member of the senate from the 2006 interim legislative health and human services committee be appointed by the chair and vice chair of that committee to serve as advisors to the task force and that the task force and advisors present conclusions, including a working definition of "uncompensated care", at the November 2007 meeting of the legislative health and human services committee; and

BE IT FURTHER RESOLVED that copies of this memorial be transmitted to the governor, the executive director of the New Mexico health policy commission, the chair and vice chair of the 2006 interim legislative health and human services committee, the secretary of human services, the secretary of health and each county indigent hospital and county health care board.

APPENDIX B

New Mexico Hospital Association Policy Statement on Uncompensated Care

Guiding Principles

1. Uncompensated Care is comprised of three elements:
 - a. The cost of charity and/or indigent care,
 - b. The cost of bad debt amounts, and
2. All such amounts should reflect costs, not charges.
3. The basis for determining charity care and/or indigent care and bad debt amounts should be based on a policy determined by the healthcare provider. The policy should be clearly documented and approved by the provider's governing body and the eligibility criteria of these policies should be communicated to patients and the community.

Overall Definition

Uncompensated care is the cost of services provided for which no payment is made or expected. In the simplest of terms it is charity care and/or indigent care charges and bad debt write-offs converted to cost.

Charity care and indigent care are services provided to patients who cannot pay for the services provided. If the patient, insurance, and/or any indigent fund provide any amount of payment for some or all of the charges, the amount not covered by such payment may be considered as charity care or indigent care. Charity care or indigent care determinations are made based on a policy of the provider. Amounts covered by an indigent fund, inclusive of any contractual allowance, are not uncompensated. Under-reimbursed amounts from any such source of payment are not charity care. The charges that meet charity care or indigent care policy are uncompensated care. These charges must be converted to cost for the purpose of determining and reporting the amount of uncompensated care.

Bad debt write-offs are also uncompensated care. Similar to charity care or indigent care, bad debt amounts are charges that must be converted to cost for the purpose of determining amounts of uncompensated care. Bad debt amounts must not include any contractual discounts or administrative allowances. Bad debt amounts often include estimates of future write-offs to meet Generally Accepted Accounting Principles (GAAP). Whether actual amounts written off or estimates of future write-offs, bad debts are gross patient charges that are unpaid.

Cost Basis for Uncompensated Care Both charity care and/or indigent care and bad debt amounts are initially gross patient charges that are unpaid. These gross patient charges must be converted to cost for the purpose of reporting of the cost of uncompensated care. There are multiple approaches to converting charges to cost. Most approaches essentially are accomplished by multiplying charges by a cost to charge ratio. The cost to charge ratio should reflect the full cost of providing care. An overall cost to charge ratio for services rendered by a provider may be computed by

dividing total costs of providing care by the total gross charges for providing care. This may be done in the aggregate with an overall cost-to-charge ratio or a department specific cost-to-charge ratio. If a department specific cost-to-charge ratio is computed the cost component of the ratio should include overhead costs allocated to revenue producing departments. The Medicare and Medicaid cost reports provide cost center specific cost-to-charge ratios, but the allowable cost as determined by the Medicare or Medicaid program is usually less than the full cost of providing services. Cost disallowances are based on Medicare or Medicaid program policy and thus the cost report allowable cost is usually less than the actual cost. Actual cost is the measurement that should be used for a cost-to-charge ratio(s) for the purpose of determining the actual cost of uncompensated care charges.

Provider Determined Policies All unpaid charges for services provided should be considered for the purposes of charity care and/or indigent care write-offs as well as bad debt write-offs. Charity care and/or indigent care and bad debt amounts should not include contractual discounts and allowances or administrative adjustments. Charity care and/or indigent care write-offs as well as bad debt write-offs should be determined based on a policy adopted by the health care provider. No single policy is applicable to all providers since each health care provider organization determines its own policy. Write-off policies for all uncompensated care amounts vary based on organizational policies. Governmental units such as counties or hospital districts often determine indigent policies. Other policies are determined based on corporate or sponsoring organizations' considerations. A single New Mexico statewide policy is not appropriate for individual providers or providers owned or managed or sponsored by national or regional organizations. The policy should be clearly documented and approved by the provider's governing body and the eligibility criteria of these policies should be communicated to patients and the community.

The Healthcare Financial Management Association (HFMA) issued Principles and Practice Statement 15¹ that states in part:

"3.1 No single set of criteria for charity care policies is universally applicable. Each provider of healthcare services must establish its own policies that are consistent with the organization's mission and financial ability"

"3.2 Charity care and bad debt policies should be clearly documented and approved by the provider's governing body. The existence and basic eligibility criteria of these policies should be communicated to patients and the community"

8.2 (paraphrasing) Bad debt determinations, like charity care determinations, should be made based on the provider's policies.

It would be inappropriate to have a single definition of charity care, indigent care, or bad debt write-offs because each provider has its own method of making such policy. Whatever the policy is, it should be uniformly applied and amounts written off based on such organizational policy should be the amounts converted to cost for the purpose of reporting uncompensated care.

¹P&P Board Statement 15: Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers.