SAN JUAN COUNTY
HEALTH CARE ASSISTANCE PROGRAM
POLICY AND PROCEDURE MANUAL

EFFECTIVE AS OF DECEMBER 10, 2008

AMENDED 7/1/2014 RESOLUTION NO. 14-15-01
AMENDED 3/17/2015 RESOLUTION NO. 14-15-37
AMENDED 3/11/2020 RESOLUTION NO. 19-20-41
AMENDED 4/1/2025 RESOLUTION NO. 24-25-66

SAN JUAN
COUNTY
NEW MEXICO
SINCE 1887

Mission Statement

The San Juan County Health Care Assistance Program's mission is to promote the health and wellness of residents of San Juan County through programs which improve access and availability of health care services in the community.

Vision Statement

The vision of the San Juan County Health Care Assistance Program is to improve the quality of life in San Juan County by identifying and addressing the health care needs of the residents of San Juan County through collaboration with community partners.

1. INTRODUCTION

The San Juan County Health Care Assistance Program ("HCAP") is a program administered by the Board of County Commissioners (“Board”) through the County’s Community Health and Social Service Director (“HCAP Coordinator”). The HCAP program was established in accordance with the Indigent Hospital and County Health Care Act, NMSA 1978 § Chapter 27, Article 5 ("Indigent Act”) to provide assistance to medically indigent patients (“Patients”) who are residents of San Juan County for authorized costs of ambulance and health care services, as defined in NMSA 1978 §7-5-4(F) and as limited by this policy ("Services"), provided by HCAP designated health care providers as defined below ("Designated Providers").

2. THE INDIGENT PATIENT

> *In order to be eligible for HCAP assistance, a Patient must be medically indigent as defined by New Mexico Statute Chapter 27, Article 5, must be a resident of San Juan County, and must **not** be eligible for Medicaid.*

A Patient who has received Services from an HCAP Designated Provider, and who can normally support himself/herself and dependents on present income and available liquid assets, but, taking into consideration this income and those assets and the requirement for other necessities of life for himself/herself and dependents, is unable to pay the costs of ambulance transportation or medical services or both is defined as medically indigent. Income shall not exceed 200% of Federal Poverty Level. Annual adjustment will automatically apply.

The term Patient includes a minor who has **been denied Medicaid coverage,** and has received Services from a Provider, and whose parent or the person having legal custody of that minor would qualify as a Patient if they received Services from a Provider.

"Necessities of life" is defined to include the costs of food, shelter, clothing, utilities and vehicle/transportation expenses.

In this policy, the Board has set financial guidelines dealing with income and assets, in addition to residency requirements, to determine if a Patient is eligible for assistance.

A. Third Party Liability

If there is a liability claim pending such as Worker’s Compensation, a lawsuit due to bodily injury, or another third-party claim, HCAP claims will be processed and held by HCAP staff until information detailing the outcome of such liability claims is provided. The Patient must demonstrate that no other source of payment exists. If the Patient has or plans to file a personal injury lawsuit, the applicant must agree to subrogation. Failure of the Patient to obtain available health care insurance through their employer or public/private source may not be considered by the Board to determine eligibility.

B. Other Assistance Programs

The HCAP is the payor of last resort.

The Provider shall make all reasonable efforts to determine whether the Patient is eligible under any other public or private assistance program, such as Medicaid, Medicare, or Indian Health Service.

The Provider shall require the Patient to apply for medical assistance through all agencies available. The Patient shall provide a letter from such agencies determining the approval or denial and this shall be part of the verification process. Failure to cooperate in seeking assistance through other government agencies will be grounds for denial of the HCAP claim.

A Provider shall not be paid by the HCAP funds for any costs when the patient has been determined by the Human Services Department to be eligible for Medicaid or any other assistance from HSD.

If a Patient has applied for assistance under the New Mexico Crime Victims Reparation Commission, the State requires that all collateral sources such as health insurance and programs such as the HCAP Program be exhausted before assistance may be granted. In these cases, the Crime Victims Reparation Commission is the payer of last resort.

C. Residency

The Patient must be domiciled in San Juan County continuously and without interruption for at least three months (90 days) prior to the date of Service. U.S. Citizenship is not required per NMSA 1978 24A-1-20.

Patients who reside out of the county for periods of time on a temporary basis, including temporary employment, job training, and full-time students with the intent to return to reside in San Juan County may be considered for HCAP assistance. Under certain circumstances, the Patient may be asked to show intent to remain in San Juan County.

A minor child is eligible for HCAP assistance only if his/her custodial parent resides in San Juan County and only if the custodial parent would qualify to receive HCAP assistance. If only one of the parents of a minor child of separated or divorced parents resides in San Juan County, the applicant must produce any Separation Agreement or Divorce Decree which pertains to the custody of the minor child and to the responsibility for payment of medical expenses.

D. Assets

"Liquid assets" is defined to include cash and all other funds in checking accounts, certificates of deposit, credit union accounts, stocks, bonds and trusts.

The liquid asset limit for a household of one is $5,000.00; for a household of two or more is $10,000.00. The asset limit for widow/widowers is $10,000.00.

Life insurance shall be exempted.

Assets may be spent down to allowable limits by paying doctor bills, other medical expenses, or burial expenses not covered under the HCAP. Documentation must be provided.

E. Income

The gross income based on the number of individuals in the household unit size cannot exceed 200% of Federal Poverty Level. Annual adjustment will automatically apply.

To determine household unit size, household members to be included are the Patient, the Patient's spouse, and the Patient's legal dependents. All Patients may be required to provide tax returns, check stubs, award letters, Profit/Loss statements, trust documents, etc. to the Provider or HCAP staff as part of the income verification process. All sources of income, earned or unearned by the household may be considered.

Current income will be considered as income received twelve months prior to the date of Service, the twelfth month will be the month of the date of Service. The income of a deceased Patient will not be included.

Additional relevant information may be required by the Provider or HCAP staff and may be requested by telephone, email and/or by a letter allowing up to thirty (30) days for the applicant to respond to such a request. Failure to comply will result in the claim being administratively denied.

F. Patient/Applicant Responsibilities

Proof of financial eligibility and residency is the responsibility of the Patient. Failure to provide the required information may lead to denial of the application. It is also the responsibility of the Patient to provide proof of all means of support from all sources. Patient must sign a "verified statement of qualification" which shall constitute an oath of the person signing it, and any false statements in the verified statement made knowingly constitute a felony (NMSA 1978 27-5-12). All applications and any information contained therein shall be subject to verification by the HCAP staff.

3. PROVIDERS

A. Eligibility

Providers eligible for HCAP funding may include certain in-state ambulance services, in-state hospitals licensed by the New Mexico Department of Health, in-state licensed home health agencies, in-state licensed hospices, licensed non-profit community-based programs providing primary and prenatal care, licensed non-profit drug and alcohol rehabilitation centers, licensed non-profit out-patient mental health agencies, and certain out-of-state hospitals licensed by their state licensing authority where treatment provided is medically necessary for the proper care of a Patient.

B. Designated Providers

HCAP Funds can only be used to reimburse those Providers/facilities whose eligibility and allowable costs are defined in the Indigent Act and the San Juan County HCAP Policy. Prior to reimbursement from the HCAP Fund, an eligible Provider must be accepted as a Designated Provider by the Board and shall enter into an agreement with the County agreeing to abide by all provisions of this policy. Such agreements may include reimbursement caps based on available funding at the discretion of the Board. Reimbursement for eligible services to Providers who are *non*-designated may be considered on a case-by-case or as-needed basis at the sole discretion of the Board and subject to availability of funds.

Approval of Designated Providers will be at the discretion of the Board. To be considered to become a Designated Provider, a Prospective Provider/Facility/Agency must submit a letter of request to the San Juan County Commission via the HCAP Coordinator to include:

- Type of provider/facility, profit status, type of services or treatment and costs provided in the facility for which you seek reimbursement.
- Current data, statistics, schedules and information deemed necessary by the Board to determine the cost for all patients cared for by that health care provider/facility or tariff rates for charges of an ambulance provider.
- Proof of licensure by the Department of Health or licensing authority as prescribed by the laws of this state or the state prospective provider is located.
- Statement of agreement to comply with all provisions contained in the San Juan County Indigent Health Care Program Policy and Procedure Manual.
- Statement of agreement to accept HCAP payment as payment in full.
- W-9.
- Any other information provider would like to include that may help determine eligibility as an allowable provider/facility under the HCAP program.

Upon receipt of a letter of request, the HCAP Coordinator will consult with the County Manager and may request additional information from the Provider/facility. The HCAP Coordinator will place the request on the agenda for consideration by the Board. The prospective provider/facility may be required to make a presentation to the County Commission in cooperation with the HCAP Coordinator. In making its determination, the Board will consider, but will not be limited to, the following:

· If the prospective provider qualifies under the Indigent Act

· The benefit /impact on county residents

· The anticipated fiscal impact on the Indigent Fund

· If there is a duplication of services

If approved by the Board, the prospective provider/facility may enter into an agreement with the County to become a Designated Provider. No reimbursement shall be made until an agreement is fully executed.

HCAP Staff will provide training on claims submission process and requirements to a new Designated Provider if necessary.

C. Rights and Duties of Providers

i. Verify Patient Eligibility:

Provider shall determine patient eligibility prior to submitting claims for reimbursement to HCAP staff. No eligibility application may be accepted by the Provider prior to the Patient receiving Services.

The applicant must be the Patient. If the Patient is a minor, a parent or legal guardian having legal custody must file the application. In the event of the death of the Patient, the applicant shall be either the surviving spouse or the executor or administrator of the estate. If the Patient is incapacitated, the applicant shall be the guardian, conservator, or other legally responsible party.

The eligibility application and income verification for Patients who have received Services will be processed by, and claims submitted by, the Providers in cooperation with the San Juan County HCAP Staff according to the terms of their Agreement if a Designated Provider or according to NMSA 1978 27-5-12. Eligibility applications and claims for reimbursement must be submitted within one hundred and eighty (180) days from the date of service or release of the patient from hospital care.

The Provider shall provide application materials, conduct an interview with each Patient, provide assistance to the Patient in completing the eligibility application, and complete the verification process. The Provider shall ensure that the eligibility application is complete and all necessary verification documents to prove eligibility are attached. The Provider must specify to the patient the date by which documentation must be provided. Care will be exercised to allow a reasonable length of time, not to exceed ninety (90) days, for the applicant to gather all necessary documentation. If the Patient requests additional time, the request may be honored, but the Patient must specify a reasonable date which may not exceed 15 days of the date of the request. Additional time may be granted only if necessary to obtain Medicaid eligibility determination. If the information is not provided by the patient, the application may be denied and a claim will not be submitted to the HCAP Coordinator.

Approved Eligibility Applications are valid for one year, except in certain cases where the HCAP staff finds that information must be updated with each claim.

If an eligibility application is denied, the Provider shall inform the patient in writing of the reasons for the denial.

ii. Claims Process

Unless separate contract provisions apply, to be considered for reimbursement for services provided, the Provider shall attach a claim statement and itemized bill to each eligibility application and submit the claim, along with the "verified statement of qualification," to the attention of HCAP Coordinator at 100 S. Oliver Drive, Aztec, NM 87410. A separate eligibility application and claim must be filed for each Patient. Failure to properly complete the eligibility application or to provide eligibility documentation may result in denial of the claim.

iii. Confidentiality

All Providers shall comply with the standards of the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

iv. Accept as payment in full

The amount approved for payment from the HCAP Funds shall be accepted and deemed by the Provider as payment in full. Any collection action against the Patient for any portion of the bill not covered by HCAP Funds is prohibited.

4. LIMITATIONS ON HCAP PAYMENTS

Payments to Providers shall be based on Medicaid rates or 33% of billed charges for services where Medicaid rates are not established, with a maximum of $10,000.00 per each claim. Payments for Services provided outside of San Juan County is limited to medically necessary inpatient hospital claims reimbursed at the DRG Medicaid rate, but not to exceed the limitations set forth herein. A Provider may be asked to certify that the billed charges are consistent with usual and customary charges.

The HCAP fund is not intended to serve as reimbursement to the Patient/guarantor for payments previously made to the Provider by the Patient/guarantor.

Payments from the HCAP fund shall not be considered for:

a) Elective services, or Services not considered a medical necessity; or

b) Treatment which includes a more expensive procedure or product when a less expensive procedure or product is available; or

c) Work-related injuries that are covered by the New Mexico Workers Compensation Act; or

d) Services that have been determined by the New Mexico Human Services Department to be generally ineligible for Medicaid reimbursement, or

e) Patients that have been determined to be eligible for Medicaid coverage whether or not they are actually receiving coverage; or

f) Medicare and other third-party insurance deductibles and co-pays, or

g) Services provided by a Qualifying Hospital under the Safety Net Care Pool that is located outside of San Juan County, or

h) Claims in the amount of $100.00 or less.

5. HCAP STAFF RESPONSIBILITIES

A. Records

The HCAP staff will retain case records for a period of not less than five years, pursuant to Resolution No. 16-17-12 and NMAC 1.21.2.813, and will require Designated Providers to do the same. Case records will be periodically purged when it is evident that the information is no longer valid or necessary and the time limit for retention of records has expired.

B. Processing Invoices or Claims

The HCAP staff will submit approved invoices for contractual HCAP services and/or approved HCAP claims to the finance department on a monthly basis for payment. The San Juan County Finance Department shall maintain all HCAP records of payment. If a claim for reimbursement is denied, HCAP staff shall inform the Provider in writing of the reasons for the denial.

C. Confidentiality

The HCAP Staff shall comply with the standards of the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). All records dealing with physical or mental examinations or medical treatment of patients are not public record and shall remain confidential unless otherwise provided by law.

6. APPEALS

A patient or Provider adversely affected by a denial of eligibility or claim under this policy may file an appeal as follows:

A. Decision by Provider

If a Patient's eligibility application is denied by a Provider, the Patient may appeal that decision to the HCAP Coordinator within (30) thirty days of the denial by completing and submitting an Appeal Form to the HCAP Coordinator. The HCAP Coordinator shall review the form and determine if additional information is necessary to proceed with the appeal. Additional information will be requested in writing. The Patient must submit any additional requested documentation within (30) thirty days of notification. Failure to comply will result in the dismissal of the appeal and the denial shall be upheld. The HCAP Coordinator shall render a

decision in writing within 30 days after receiving notice of the appeal or, if additional information is required, 30 days after receipt of all requested additional information whichever is later.

B. Decision by HCAP Coordinator

If a claim/application is denied by the HCAP Coordinator, the adversely affected party may appeal that decision to the County Commission by completing and submitting an Appeal Form to the County Manager within (30) thirty days of the denial. The Board shall hear the appeal at a regularly scheduled Board meeting. If a Patient is challenging denial of eligibility, the Patient is required to attend the Board meeting and state his/her case in person. If the Patient is unable to appear, he/she may, in writing, designate another to speak on his/her behalf. The Board shall render a decision in writing within 60 days after receiving Notice of Appeal.

C. Decision by the Board

A Patient or Provider who is adversely affected by a decision of the Board of County Commissioners under this policy may appeal that decision to the District Court within (30) thirty days of the action of the Board.