



**VALENCIA COUNTY
BOARD OF COUNTY COMMISSIONERS
Resolution 2014-25**

**A RESOLUTION
RELATING TO INDIGENT HOSPITAL CLAIMS; ESTABLISHING GUIDELINES,
RULES AND REGULATIONS FOR INDIGENT HOSPITAL & COUNTY
HEALTHCARE CLAIMS.**

WHEREAS, all indigent claims for Valencia County must be administered in accordance with the provisions of the New Mexico Indigent Hospital & County Health Care Act, NMSA 1978 Section 27-5-1 *et seq.*; and,

WHEREAS, all NMSA 1978, Section 24-13-1 *et seq.* describes how the indigent fund must be utilized for the burial or cremation of unclaimed decedents and of indigents; and,

WHEREAS, the Board of County Commissioners are responsible for administering and operating an Indigent Hospital Claims program for the County sitting as the county Indigent Claims Board; and,

WHEREAS, the Indigent Claims Board desires to define its policy by adopting regulations, rules and procedures governing claims eligibility requirements and financial reimbursement to the eligible hospital, health care providers and ambulance services.

NOW, THEREFORE, BE IT RESOLVED by the governing body of Valencia County hereby adopts the following **“Valencia County Indigent Hospital Claims Program Guidelines”**.

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PREFACE

The "Valencia County Indigent Hospital Claims Program Guidelines" were originally adopted by Resolution Number 88-1, effective January 11, 1988. The guidelines reflect the recommendations made by the Indigent Claims Committee and Indigent Claims Administrator to the Board of County Commissioners.

1. PURPOSE OF THE INDIGENT HOSPITAL AND COUNTY HEALTHCARE ACT

The purpose of the Indigent Hospital and County Healthcare Act is to recognize that Valencia County is the responsible agency for ambulance transportation, hospital care or the provision of health care to indigent patients domiciled in that county for at least 45 days, or unless they are in the custody of the Valencia County Detention Center, in addition to providing support for the State's Medicaid program. The Act recognized that Valencia County is Responsible for supporting indigent patients by providing local revenues to match federal funds for the State Medicaid program pursuant to Section 7-20E-9 NMSA 1978 and the transfer of funds to the county-supported Medicaid fund pursuant to the Statewide Health Care Act. Furthermore the

Act recognizes that Valencia County can improve the provision of health care to indigent patients by providing local revenues for countywide or multicounty health planning.

2. DEFINITIONS

- A. "Administrator" means the Indigent Hospital & County Healthcare Administrator.
- B. "Ambulance Provider" or "ambulance service" means a specialized carrier based within the state authorized under provisions and subject to limitations as provided in individual carrier certificates issued by the public regulation commission to transport persons alive, dead or dying en route by means of ambulance service. The rates and charges established by public regulation commission tariff shall govern as to allowable cost. Also included are air ambulance services approved by the county. The air ambulance service charges shall be filed and approved pursuant to Subsection D of Section 27-5-6 NMSA 1978 and Section 27-5-11 NMSA 1978.
- C. "Board" means the County Indigent Hospital Claims Board. The Board shall be composed of the members of the Board of County Commissioners and the Chair of the Board of County Commissioners shall be the Chair of the Board. Statutory authority given to the Board is under Section 27-5-5, NMSA 1978.
- D. "Cost" means all allowable costs of providing health care services, to the extent determined by resolution of a county, for an indigent patient. Allowable costs shall be based on Medicaid fee-for-service reimbursement rates for hospitals, licensed medical doctors and osteopathic physician.
- E. "Fund" means the Valencia County health Care assistance fund.
- F. "Health Care Services" means treatment and services designed to promote improved health in the county indigent population, including primary care, prenatal care, dental care, behavioral health care, alcohol or drug detoxification and rehabilitation, hospital care, provision of prescription drugs, preventive care or health outreach services, to the extent determined by this resolution.
- G. "Indigent Patient" means a person to whom an ambulance service, a hospital or a health care provider has provided medical care, ambulance transportation or health care services and who can normally support the person's self and the person's dependents on present income and liquid assets available to the person but, taking into consideration the person's income, assets and requirements for other necessities of life for the person and the person's dependents, is unable to pay the cost of the ambulance transportation or medical care administered or both; provided that if a definition of "indigent patient" is adopted by a county in a resolution, the definition shall not include any person whose annual income together with that person's spouse's annual income totals an amount that is fifty percent greater than the per capita personal income for New Mexico as shown for the most recent year available in the survey of current business published by the United States department of commerce, unless that person is a prisoner or inmate. "Indigent patient" includes a minor who has received ambulance transportation or medical care or both and whose parent or the person having custody of that minor would qualify as an

indigent patient if transported by ambulance, admitted to a hospital for care or treated by a health care provider. The following constitute Additional Eligibility Considerations:

- i. New Mexico Human Services Department (NMHSD) benefit recipients who lose their Medicaid coverage by choice due to the lack of cooperation with NMHSD shall not be eligible for the Indigent Hospital Claims Program.
- ii. The Indigent Hospital Claims Board will exclude claimants that are “indigent by choice”. These are unemployed persons who do not wish to work until their unemployment checks expire or refuse to accept employment at a lower wage than they previously received.
- iii. Failure by the patient to be covered for medical insurance through the Affordable Care Act (ACA) or by their employer will not affect eligibility.
- iv. Prisoners or inmates in the custody of the Valencia County Detention Center shall be considered indigent patients for the purpose of this resolution.

H. “Medicaid Eligible” means a person who is eligible for medical assistance from the New Mexico Human Services Department.

I. “Planning” means the development of a countywide or multicounty health plan to improve and fund health services in the county based on the county's needs assessment and inventory of existing services and resources and that demonstrates coordination between the county and state and local health planning efforts.

J. “Provider” refers to a qualifying hospital, health care provider, ambulance service provider, funeral home or the county as a provider of inmate health care.

K. “Public Entity” means a state, local or tribal government or other political subdivision or agency of that government.

L. “Qualifying Hospital” means an acute care general hospital licensed by the department of health that is qualified to receive payments from the safety net care pool pursuant to an agreement with the federal centers for Medicare and Medicaid services.

3. THE APPLICANT

A. The applicant may be the patient, the patient’s spouse, patient’s parent or patient’s guardian if the patient is a minor or the guarantor of the hospital bill. If the patient is a prisoner or inmate the applicant may be the Detention Center Warden or his/her designee on behalf of the patient. In the event of the death of the patient, the personal representative or relative of the deceased, if any, will be the applicant. The applicant for the deceased may be the person responsible for the hospital, health care provider or ambulance bill, or may be any interested party providing information on behalf of the deceased.

B. The application shall be filed at the hospital, health care facility, funeral home or ambulance service where assistance was received, or at the office where the provider

maintains their central business office. The provider shall render assistance to the applicant when filling out the application. The application may also be completed by the indigent patient and/or applicant if the hospital, health care facility, funeral home or ambulance service was not aware the patient was indigent.

4. ELIGIBILITY REQUIREMENTS

- A. **RESIDENCY** - The indigent patient must reside in Valencia County for not less than 45 days immediately prior to medical care with the intent to settle in the county for employment, education and/or retirement, unless the person is a prisoner or inmate.
- i. Students residing in Valencia County will be considered for the Fund and shall meet the same criteria for residency and income as herein stated. Valencia County residents attending school and residing outside the county will be covered by the Fund if there are no other funds available to them, providing they meet the eligibility requirements.
 - ii. Prisoners or inmates shall be considered Valencia County residents while in the legal custody of the Valencia County Detention Center.
 - iii. Driver's license, identification card, utility bills, federal and state tax returns, County property tax bills and voter registration shall be considered proof of residency.
- B. **INCOME** - Income shall be considered as any money received in the household including, but not limited to:
- i. Gross Annual Income from wages;
 - ii. Workmen's Compensation payments;
 - iii. Social Security or Supplementary payments;
 - iv. NMHSD benefits eg. food stamps, cash assistance etc.;
 - v. Pensions/ retirement income;
 - vi. Unemployment Benefits
 - vii. Unearned Income.

The applicant's and/or patient's gross annual income together with household member's income cannot exceed 150 percent of the federal Income Poverty Guidelines as established by the federal Department of Health and Human Services for household income standards. This amount will change annually. The countable income of a deceased individual shall not be included for the 12 month period if death occurred within the time of medical care. Applicant must also meet the definition of indigent at the time of payment of the claim.

1. COMPUTATION OF INCOME

- a. 150 percent of federal Income Poverty Guidelines as established by the federal Department of Health and Human Services (changes annually).
- b. Self-employed individuals, seasonal workers and part-time employee's income will be calculated by using present income, prior year's tax return and/or any

other proof of income for each month prior to the application. Income of self-employed individuals is that income shown as net profit or loss on Form 1040, Schedule C, plus any other source of income.

- c. Wages which are stable and on-going use the income tax return or compute the income by obtaining the employer's letters of income verification for the 90 days prior to application. The worker may also use the year to date earnings shown on the wage stubs for determining income.
- d. Income which is on-going but is variable: Use a combination of the prior year's income tax return and verification of income by employers or the viewing of the check stubs.

2. SPECIAL CIRCUMSTANCES FOR CONSIDERING INCOME

- a. Unwed mothers: Include child support, alimony or any other financial compensation received from the baby's father when determining income.
- b. Unwed individuals living together with or without children: Consider their income the same as married couples.
- c. Separated or Divorced couples: The claimants shall provide the Fund with copies of the divorce decree for determination of income to be considered.
 - i. Count the income for the period the couple was living together for the 90 days prior to the application, if separated less than 90 days.
 - ii. Count all income or other resources of the ex-spouse for the months prior to the effective date of the divorce (if the effective date is within the 90 days being reviewed), and any other income or resources which may have been judicially ordered. If separated before the divorce also use number 1) of this section.

5. OTHER ASSISTANCE

- A. The provider shall inform the Administrator if the patient is applying for or is eligible for other public or private assistance programs. The Administrator shall, if the patient is possibly eligible for other assistance, notify the provider. Amounts shall only be paid after all other sources have been exhausted or have paid their benefit, i.e., Medicaid, Medicare, insurance settlements, own health insurance or funding from other agencies.
- B. It is the responsibility of the patient/applicant to provide proof of all means of support from whatever source, whether that support is the result of dependent status or voluntary support by a third party not necessarily having legal responsibility for financial support. Lack of income with no visible means of support other than voluntary contributions from a third party does not relieve the patient/applicant of the responsibility for providing proof of indigence on the person who provides support to the patient. If the person

providing support is unwilling to voluntarily claim and prove indigence for the applicant, the patient shall be ineligible for Fund consideration.

6. LIABILITIES

If there is a liability claim pending, such as workmen's compensation, a lawsuit due to bodily injury, or another third party claim, the hospital, health care provider and/or ambulance service will notify the Administrator in writing, process the application and hold it until information detailing the outcome of such liability claim is provided and will then forward it to the Administrator for consideration.

7. LIQUID ASSETS

Liquid assets are readily negotiable resources such as but not limited to; cash on hand, real estate contracts, rental property, money in checking and/or saving accounts, saving certificates, stocks, savings bonds and nonrecurring lump sum payments. All assets kept in repositories must be reported. Applicants with household liquid assets valued over \$10,000 or with individual liquid assets valued over \$5,000 are not eligible for indigent assistance.

8. REAL ESTATE

If the patient/applicant owns real estate other than his home and the land on which his home resides with a maximum of 3 acres being exempt, the real estate shall be considered part of his income or assets. If the land is used as farming to produce his income then the land will be considered part of his business and will be exempt as far as real estate assets are concerned. All real estate must be listed on the application. Any individual with real estate assets beyond the exempt amount as detailed in this section shall not be eligible for indigent assistance.

9. LIMITATIONS OF CLAIMS

- A. Elective medical services shall not be covered by the fund.
- B. No more than one lifetime claim for childbirth cost for any one indigent patient. The Fund will pay for a tubal ligation as long as the patient had the tubal ligation while being hospitalized for childbirth purposes.
- C. The maximum amount to be paid to the medical provider for one indigent person in a 12 month period would be \$3,000 of the approved claims, with no more than \$3,000 being paid in a 12 month period. If the patient is a prisoner or inmate, the maximum amount to be paid to the medical provider in a 12 month period would be \$5,000 of the approved claims, with no more than \$5,000 being paid in a 12 month period. In the event a provider has contracted with a county for provision of health care services, the Board may determine the maximum to be paid under such contract. The allowable cost shall be based on Medicaid fee-for-service rates for hospital, licensed medical doctors, osteopathic physicians and other health care providers as defined by NMSA 1978, Section 27-5-4 (N) (2001).
- D. Ambulance Service

- i. When an ambulance is necessary based on the patient's medical condition.
 - ii. The maximum amount to be paid for each approved ambulance claim will be the base rate in addition to mileage, not to exceed \$400 with a 2 trip limit per 12 month period.
- E. No more than a one lifetime claim for self inflicted injuries. Each claim will be reviewed on a case by case basis.
 - F. To the extent that a deceased person is indigent the burial or cremation expenses shall be paid by the fund in an amount up to six hundred dollars (\$600) for the burial or cremation of any adult or minor as provided in NMSA 1978, Section 24-13-3 2001).
 - G. The Board after proper investigation shall cause any deceased indigent or unclaimed decedent to be decently interred or cremated. The cost to be paid by the fund of opening and closing a grave shall not exceed six hundred dollars (\$600), which sums shall be in addition to the sums enumerated in NMSA 1978, Section 24-13-3 (1999).

10. PROCEDURE FOR FILING CLAIM

Refer to Section 3 - **Applicant** as to who is considered an applicant.

- A. All claims for payment shall be filed within 365 days from the last day services were rendered. If services were not rendered on consecutive days, it will be the within 365 days from last day of service for each service.
- B. Claims shall be filed separately for each patient per incident with an itemized detail of costs.
- C. A hospital, ambulance service or health care provider that has contracted with a county for provision of health care services shall provide evidence of health care services rendered for payment for services in accordance with the procedures specified in the contract per NMSA 1978, Section 27-5-12 (B).
- D. Applications shall be filed by the provider or patient/applicant.
- E. **Provider Responsibilities**
 - i. Assist applicant in filing the Fund application.
 - ii. To verify that the patient/applicant does meet indigent guidelines.
 - iii. To provide the applicant with a list stating the documents needed to provide the information necessary to complete the verification process.
- F. **Applicant's Obligations**

- i. If the applicant requests additional time for acquiring information, the request shall be honored, although the applicant will be advised by the Administrator of a reasonable date to receive the information requested. If the information is not provided, the Administrator will send a letter requesting the information and will allow 13 days for the applicant to provide the information. If the information is not provided, the claim will be denied.
- ii. If the applicant does not show for the appointment and has not informed the administrator that they would not be able to attend the appointed date, a letter will be sent requesting they call and schedule another appointment allowing them 13 days to reschedule. If an appointment is not made within the 13 day time limit, the claim will be denied.
- iii. In the event of a denial, a letter by certified mail with a Return Receipt will be sent to the patient/applicant notifying they have 30 days from the date of the letter to request an appeal in writing. The applicant must appeal to the Administrator by letter notifying of their desire to appeal. The applicant must appeal to the Board at a regularly scheduled meeting.

11. PAYMENT OR REJECTION OF CLAIMS BY BOARD

- A. The Board shall receive the written recommendation of the Administrator at a regular or special Board meeting.
- B. The provider and applicant will be notified of Board denial in writing – Certified Return Receipt letter to applicant.
- C. A patient/applicant or his/her representative may appeal a denial by writing to the Administrator within 30 days of the date of the denial letter. The administrator will then set up a date and time with the Indigent Claims Board. A letter to the person requesting the denial will be sent Certified Return Receipt showing the date, time and place of the appeal. If additional information is required, the Administrator shall request the information.
- D. If the applicant or representative fails to show up for the scheduled appeal it will automatically be denied. In the event the patient or representative knows they will not be able to attend the appeal due to extenuating circumstances, the Administrator must be informed prior to the meeting and proof as to the circumstances may be requested.

12. SUBROGATION OF CLAIMS

Payment to a hospital from the fund of any claim shall operate as an assignment to the board of any cause of action to the extent of the payment from the fund to the hospital.

13. BOARD TO RECOVER COSTS, PRESUMPTION OF PAYMENT

- A. The payment of any claim to an ambulance service, a hospital or health care provider on behalf of an indigent patient creates a preferred claim in favor of the fund against the

estate of the indigent patient and a lien against all real property or interest in real property vested in or later acquired by the indigent patient or any person legally responsible for his debts for the amount of the payment made from the fund to the ambulance service, hospital or health care provider, without interest. Such claims shall be preferred over all claims except charges of the last sickness and funeral of the deceased and allowances made by the court for the maintenance of the widow and children, taxes, municipal levies, cost of administration and attorneys' fees.

- B. Proceeds recovered from such claims shall be placed into the fund.
- C. The board shall file a certificate of payment to the ambulance service, hospital or health care provider on behalf of the indigent patient. The certificate shall constitute notice to the public that the lien created by the Indigent Hospital and County Health Care Act has attached. County clerks shall receive, index and file certificates and releases of liens created by the certificate, free of charge.
- D. In all cases where a lien has been created under Subsection A of this section and a period of fourteen years has passed from the date the lien was created by the payment of any claim to an ambulance service, a hospital or health care provider on behalf of an indigent patient, the payment for which the lien is claimed shall be discharged due to the passage of time and the board shall file a certificate releasing the lien due to the lapse of time.

14. CLAIM SHALL NOT EXPIRE BECAUSE OF LACK OF FUNDS; PRIORITY OF CLAIMS

A claim made to the board for payment for the care of an indigent patient shall not expire or become invalid because of the lack of money in the fund during any fiscal year but shall be carried over into the ensuing fiscal year and, notwithstanding the provisions of any other law, shall be paid in the ensuing year. Whenever the balance of the fund is inadequate to pay all qualified claims as they become due, the claims of in-state hospitals providing acute medical care shall have priority for payment over all other claims regardless of the dates the other claims were submitted. The board shall, however, on a regular basis, estimate future demands upon the fund, based on past experience, and set aside sufficient funds to assure payment for in-state hospitals providing acute medical care and shall then address, on a regular basis, the claims from other hospitals or ambulance services.

15. LIMITATION ON LIEN

The provisions of Subsections A through C of Section 27-5-14 NMSA 1978 shall not apply to any county having adopted a sales tax for the support of indigent hospital patients pursuant to the provisions of Sections 7-21-1 through 7-21-7 NMSA 1978.

16. MISCELLANEOUS

- A. In the event that the Fund shall make all or partial payment of the indebtedness of the patient to the hospital, health care facility, funeral home or ambulance service as a condition of receipt of such payment by the provider, the provider shall forgive the balance due from the patient.

- B. The Board shall reject any kind of fraudulent claims that are made against the Fund.
- C. The Board may set temporary lower payment limits of lower percentages of payment during periods when adequate funds are not available in order to discharge the maximum number of pending claims. On the other hand, the Board may set temporary higher payment limits for payment during periods when funds are available, when the Fund has more funds than are needed based on previous claims.
- D. The meeting of a Board quorum which is held for the purpose of approving, denying, and/or hearing appeals of applicants or to discuss business within their authority shall be an open meeting. The Board will use a numbering or lettering system to keep confidential the identity of the individual whose claims are being discussed. The Fund shall be public record, including application to the Fund and payment from the Fund. However, the treatment, diagnosis, name and address of the applicant and household members and the itemized statement shall be considered confidential and shall be reviewed only by the Board and Administrator.
- E. Case Records. The Indigent Administrator will retain case records in their files for a period of not less than 5 years. The Administrator may destroy their files when the information is no longer valid nor necessary and the time limitation for the retention of these records has expired.
- F. The Administrator shall, in carrying out the provisions of the Indigent Hospital Claims Program, comply with the standards of the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

17. REPORTING

The Administrator shall file an annual report on all indigent health care funding by the county with the commission. The report shall contain the county's eligibility criteria for indigent patients, services provided to indigent patients, restrictions on services provided to indigent patients, conditions for reimbursement to providers of health care, revenue sources used to pay for indigent health care and other related information as determined by the commission. The report shall be submitted by October 1 of each year on a form provided by the commission. The commission shall make the report available to interested parties.

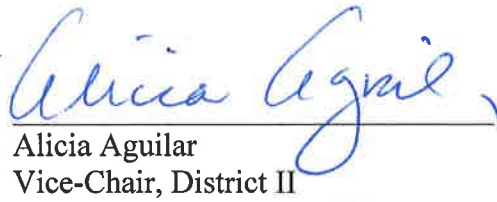
18. REPEALER CLAUSE

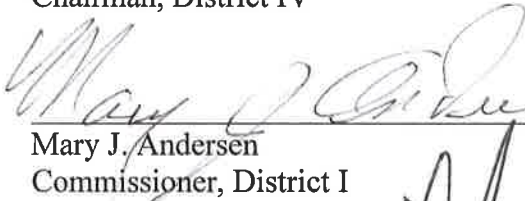
All other resolutions and parts of any resolutions of the County that are in conflict with this Resolution are hereby repealed, including resolutions 1988-1, 1989-16,19 92-35, 1994-33, 99-50, 2005-47 and 2010-16.

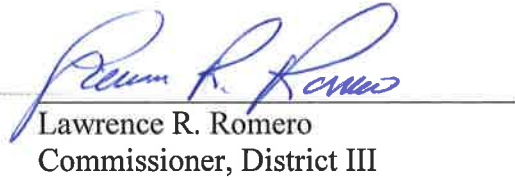
PASSED, APPROVED and ADOPTED on this 21st day of May, 2014.

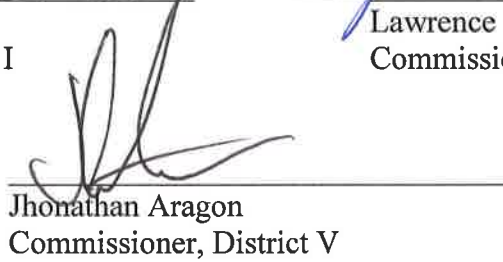
BOARD OF COUNTY COMMISSIONERS

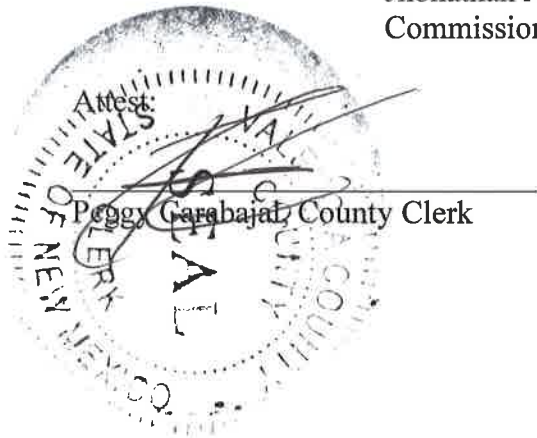

Charles D. Eaton
Chairman, District IV


Alicia Aguilar
Vice-Chair, District II


Mary J. Andersen
Commissioner, District I


Lawrence R. Romero
Commissioner, District III


Jhonathan Aragon
Commissioner, District V

Attest:

Peggy Garabaja, County Clerk

