Harrisburg Medical Center, Inc.

Title: Financial Assistance Policy Number: **100.500-3**

Donald H. Hutson 04-29-2021 Board of Directors: 04-29-2021
CEO (Date) (Date)

I. **POLICY STATEMENT**:

Harrisburg Medical Center is committed to serving our community and grants financial assistance, in the form of free or discounted care to uninsured and insured applicants who meet the criteria of this policy. Harrisburg Medical Center does not discriminate in the provision of care based upon an applicant's race, color, sex, national origin, disability, religion, age or sexual orientation.

II. **POLICY OVERVIEW:**

A. The Financial Assistance Policy (FAP) applies to Harrisburg Medical Center and all hospital owned clinics, hospital employed providers or contracted providers whose services are billed by Harrisburg Medical Center. A list of providers is available on the hospital's website or upon request to the Financial Counselor.

B. This FAP applies to all emergency and other medical necessary care provided for the diagnosis and treatment of illness or injury to insured and uninsured patients.

1. An uninsured patient is defined as a person without health care insurance.

2. An insured patient is defined as a person with health care insurance such as Medicare, Medicaid, or commercial health insurance for out-of-pocket costs such as 1) deductible, co-insurance, and co-payment, 2) costs not covered by the health care insurance, 3) out-of-network costs, 4) charges for otherwise insured applicants that have exhausted their health plan benefits and are liable for any remaining amount.

C. The FAP does not apply to certain services such as:

1. Elective cosmetic or aesthetics treatments or procedures, such as but not limited to Botox

2. Prescription medicine administered in a medically supervised healthcare setting for treatment of resistant depression, such as but not limited to Spravato

3. Swing bed program

4. Specialty lens implanted during cataract surgery

5. Cardiac Rehab Phase III

D. FAP allowances are not given to employees or providers unless they meet the criteria of this policy.

E. Providers delivering care in the hospital, which are not covered by the FAP, are cardiologists, hospitalists, emergency department, gastroenterologists, pediatric cardiologists, nephrologists, obstetrics and gynecologists, nephrologist, neurologist/sleep medicine, oncologist/hematologist, ophthalmologists, pathologists, podiatrists, psychiatrists or mental health not employed by the hospital, pulmonologists not employed by the hospital, urologists, radiologists, surgeons not employed by the hospital, and family practice providers not employed by the hospital. A list of non-billable providers is available on the hospital's website or upon request to the Financial Counselor.

F. Harrisburg Medical Center reserves the right to deny financial assistance for reasons not specifically stated in the FAP at the sole discretion of the Chief Financial Officer.

III. PATIENT NOTIFICATION & SIGNAGE

A. Patient Financial Services, Registration, and Clinics. Each department listed will be responsible and accountable for:

1. Informing patients and their families of the availability of the FAP and instructing patients in the procedure to apply.

2. During the registration process the Hospital Registration Clerk or Clinic Receptionist will give uninsured patients the Plain Language Summary.

3. Making copies of the Financial Assistance application and Plain Language Summary readily available.

4. Referring the applicants to the Financial Counselor for assistance.

B. Appropriate signage will be posted in the hospital to create awareness of the FAP. At a minimum, signage shall be posted in all patient admission/registration intake areas in the Emergency Department, Clinics and Business Office. Written material about the Financial Assistance program shall also be placed in these areas.

C. Information about the FAP and application process shall be posted on the hospital's website along with a copy of the FAP, Application, Income Guidelines and Plain Language Summary.

D. The billing statement for guarantors shall contain a statement regarding how to obtain a copy of an itemized bill and how to apply for financial assistance.

IV. FINANCIAL COUNSELOR RESPONSIBILITIES:

A. Informing patients and their families of the availability of the FAP and instructing applicants in the procedure to apply.

B. Assisting applicants in completing the application if they request it.

C. Screening, reviewing, documenting and otherwise preparing applications for processing.

D. Notifying the applicant in writing of the allowance decision.

E. Monitoring the Federal Register for updates to the federal poverty guidelines (FPG), updating and publishing the Income Criteria table on which this policy is based. The updated Income Criteria Table will become effective automatically on the first of the month following publication of the FPG guidelines in the Federal Register.

V. APPLICATION GUIDELINES:

A. An individual may apply for financial assistance by completing the Financial Assistance Application prior to service or from the date of service through the 240th day after the first guarantor billing statement. This is known as the Application Period.

B. The applicant has 30 days to return the Financial Assistance Application and all required documentation.

C. An applicant for financial assistance under this FAP must apply for all eligible funds from local, state, or federal programs before a determination of eligibility.

D. An allowance is only applicable after all insurance has been billed and collected, and/or other potential third-party resources have been explored and exhausted. Failure of an applicant to cooperate with claims filing or collecting from a potential third-party resource may result in a denial of the application.

E. The Financial Assistance Application focuses on identifying the size of the family unit and requests the applicant provide financial information to determine if the applicant qualifies for an allowance.

    1. "Family" means, using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage (including common law spouse and civil union), or adoption.

    2. According to the Internal Revenue Service rules, if the individual is allowed to claim someone as a dependent on their tax return, they may be considered a dependent for purposes of the provision of financial assistance.

F. The applicant will be asked to provide proof of gross family income. Following is a list of criteria used to establish income:

    1. Earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Social Security Income, public assistance, veteran's payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, assistance from outside the household, and other miscellaneous sources;

    2. Noncash benefits (such as food stamps and housing subsidies) do not count as income;

    3. Determined on a before-tax income basis (i.e. gross income);

    4. Excludes capital gains or losses;

    5. If a person lives with family, includes the income of all family members as defined in E.1.

G. Proof of income may be in the form of the most recent pay stubs, Social Security income or letter, Worker's Compensation letters, Unemployment Compensation Determination letters, last year's official filed Federal tax return, and other records documenting the year-to-date income.

    1. If an applicant does not have copies of their official filed Federal tax return they must contact the IRS to obtain copies.

2. If an application is received in January, February or March and a Federal tax return has not been filed, the most recent year's Federal tax return and other records documenting year-to-date income will be accepted. For applications received in April through December a current year Federal tax return is required.

3. Self-employed is defined as working for oneself as a freelancer or the owner of a business rather than for an employer. The business may be set up as a sole proprietorship, partnership or as a member (i.e. owner) of a limited liability company that does not elect to be treated as a corporation. If the applicant or member of the family is self-employed the following proof of income is required:

4. Official filed copy of the most recent Federal tax return. Another year's official filed copy of a Federal tax return and Form 4506-T may be requested.

5. If the most recent Federal tax return is more than 6 months old, then other records documenting year-to-date income is required such as an interim financial statement.

6. Carryover for net operating loss from prior year(s) will be excluded.

7. Prepaid expenses will be excluded.

8. Depreciation (i.e. Form 4562) will be excluded.

9. Any deductible expenses claimed which exceed 25% of gross income will require documentation supporting the expenses and may be excluded.

H. If an application is received with incomplete or missing information the Financial Counselor shall notify the applicant in writing of information needed to complete the application.

I. Falsifying information on an application will be grounds for denying or revoking an allowance. Falsifying an application includes but is not limited to failure to disclose income.

J. A Financial Assistance Application received after the 240 day Application Period cannot be considered for financial assistance.

K. If an applicant has been previously approved for financial assistance and receives additional services which qualify for financial assistance within 12 months of the original approval date, the applicant is not required to complete the application process again. During the 12 month approval period applicants are responsible to update the application if any changes have occurred such as new sources of income.

VI. **EVALUATION GUIDELINES**:

A. All evaluations are to be completed in a uniform and consistent a manner.

B. The Department of Health and Human Services Federal Poverty Guidelines (FPG) as published annually in the Federal Register will be the basis for qualifying applicants.

1. An applicant qualifies for a 100% allowance if their income is at or below 200% of FPG.

2. An applicant qualifies for a partial allowance if their income is between 200% and 300% of FPG. (i.e. sliding scale). See attached Income Guidelines.

3. Approval for a one time date specific allowance greater than that called for under the above income criteria may be indicated granted for documented extenuating circumstances such as medical indigence.

    a. To be eligible an applicant's total medical expenses billed as the applicant's responsibility must exceed 25% of the applicant's gross annual income and annual gross income must be less than 500% of FPG.

    b. For the purpose of this policy medical expenses are the costs to treat or prevent an injury or disease, such as hospital visits, office visits, and prescription drugs that a guarantor is responsible to pay out of pocket.

4. The following documentation must be submitted with the application for current medical bills or a lookback period of no more than 12 months:

    a. If the applicant is uninsured, a complete listing of the medical bills including a copy of the most recent guarantor billing statements for each debt. Proof of payment is not required.

    b. If the applicant is insured, an Explanation of Benefits or documentation from their insurer which states year-to-date patient responsibility (i.e. Out of Pocket amount spent). Proof of payment is not required.

C. If a patient meets the Presumptive Eligibility categories listed below the patient shall not be required to complete the Financial Assistance Application and shall be deemed to receive a 100% allowance. Presumptive Eligibility categories:

1. Homelessness which is defined as an individual without permanent housing who may live on the streets, stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle, or in any other unstable or non-permanent situation.

2. Deceased with no estate.

3. Mental incapacitation with no representative.

4. Medicaid eligible but not on date of service if within the Application Period.

5. Medicaid eligible, on date of service, for the following: hospital inpatient co-pays, hospital non-covered inpatient days, hospital and professional non-covered charges and unmet spenddown amounts.

6. Medicaid eligible patients with out of state coverage in which Harrisburg Medical Center is not enrolled for billing.

7. Incarceration in a penal institution.

D. Applicants who are eligible for financial assistance will not be expected to pay more for emergency or other medically necessary care than the amounts generally billed (AGB) to individuals who have insurance covering such care. The method used for calculating the

AGB for the hospital and clinics is the "look back" method based on all claims allowed by Medicare Fee-for-Service and all private payors. The hospital has a written Billing and Collection Policy which contains the AGB. The public may obtain information about the AGB calculation(s) and the Billing and Collection Policy free of charge by appointment during regular office hours. To schedule an appointment, contact the Financial Counselor in the Patient Accounts department at 100 Dr. Warren Tuttle Drive, Harrisburg IL 62946 or call (618)253-7671 ext. 10251.

1. For the purposes of an insured applicant eligible for financial assistance, the AGB limitation is applicable only to the amount the guarantor is personally responsible for paying after all reimbursement has been applied, even if the total amount paid by the individual and the insurer exceeds the AGB.

E. During the Application Period all collection efforts will be suspended and documented in the patient's account. No payment is required from the guarantor and accounts will not be placed with an outside collection agency pending determination of eligibility. If the account has already been placed with an outside collection agency, the agency will be notified by the Financial Counselor to suspend collection efforts until a determination is made. This notification will be documented in the account notes. The applicant will be notified verbally that collection activity will be suspended during consideration.

F. During the Application Period all Extraordinary Collection Action (ECA) will be suspended, pending determination of eligibility. ECA may include any of the following actions taken in an effort to obtain payment on a bill for care:

1. Report to credit agencies that a debt is owed by the individual;

2. Sell the debt for the hospital care and services to a third party;

3. Commence a civil action against the individual.

4. If the application is processed and the applicant is eligible under this policy, steps will be taken to reverse ECA that has begun, even if the actions were permissible when taken.

G. The following thresholds apply to Financial Assistance Applications:

1. Applications up to $2,500 may be approved by the Financial Counselor.

2. Applications between $2,501 and $9,999 may be approved by the Patient Accounts Supervisor or Director of Patient Financial Services.

3. Applications over $10,000 must be approved by the Chief Financial Officer.

H. The Chief Financial Officer will be consulted for guidance when necessary to adjudicate a complex or difficult application.

I. A written decision will generally be mailed within 14 days of receipt of a completed application.

1. If the financial assistance allowance is less than 100% the letter will notify the guarantor to contact the Financial Counselor to establish a reasonable payment plan as defined by the Billing & Collection Policy.

2. If the guarantor complies with the payment plan that has been agreed to by the hospital, the hospital shall not otherwise pursue collection action against the guarantor.

3. If the guarantor does not comply with the payment plan that has been agreed to by the hospital and guarantor or does not contact the Financial Counselor to establish a payment plan, collection activity shall commence.

4. If the applicant has a change in their financial status, the applicant should promptly notify the Financial Counselor. The applicant may request to apply for Financial Assistance based on their change in financial status if within the Application Period.

J. HMC refunds payments for care that exceed the amount the guarantor is personally responsible for paying under the FAP, unless such excess amount is less than $5.00 and no refund will be made.

VII. HOSPITAL UNINSURED PATIENT DISCOUNT ACT – APPLIES TO HOSPITAL PATIENTS ONLY.

A. The Act requires all hospitals to provide discounts from charges to uninsured hospital patients meeting certain eligibility criteria. The discounts must result in bills of no more than 135% of cost. There is also a maximum collectible amount of 25% of annual family income for those who meet the eligibility criteria and do not have significant assets. See separate policy for Hospital Uninsured Patient Discount Act.

VIII. COVID-19 PANDEMC DURING THE PUBLIC HEALTH EMERGENCY

A. The Provider Relief funds are used to support healthcare related expenses attributed to the treatment of uninsured individuals with COVID-19 on or after February 4, 2020 until the end of the public health emergency. Funds were received by Harrisburg Medical Center for this purpose.

B. The procedure outlined below covers all care, defined as COVID-19 test, treatment or vaccine, for a presumptive or actual case of COVID-19 during the public health emergency.

1. A presumptive case of COVID-19 is a case where a patient's medical record documentation supports a diagnosis of COVID-19, even if the patient does not have a positive in vitro diagnostic test result in his or her medical record.

C. Uninsured Patients will not be billed as self-pay. The following will apply:

1. Hospital and clinic charges up to $9,999 will be 100% FAP allowance

2. Charges greater than $10,000 will be reviewed for the following options.

a. Eligibility for Illinois Medicaid for medical benefits,

b. Submission of claim to the HFS Uninsured Testing Program,

c. Submission of claim to HRSA Uninsured Program,

d. 100% FAP allowance as approved by the CFO.

D. Insured Patients who are In-Network will be billed per the health plans Explanation of Benefits.

E. Insured Patients who are Out-of-Network will be discounted as follows. This includes Insured Patients whose health plans do not provide COVID-19 In-Network benefits such as limited benefit plans or ERISA plans.

    1. COVID-19 tests will be billed to guarantor at the Medicare reimbursement rate.

    2. Vaccine charges will be 100% FAP allowance.

    3. Hospital charges for COVID-19 presumptive or actual treatment will be adjusted by the AGB discount and a statement sent to the guarantor for the remaining self-pay balance.

    4. Rural Health Clinic charges for treatment will be adjusted by a 25% FAP allowance and a statement sent to the guarantor for the remaining self-pay balance.