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Area	Patient Accounts-Business Office

Healthcare Assistance Program and Presumptive, HB-PI-003

I. POLICY

Consistent with Harrisburg Medical Center's mission, vision, values and strategic plan, HMC believes that it has a responsibility to meet the financial needs of the patients and the community it serves that has an inability to pay for healthcare services. This policy provides guidance for meeting this responsibility. Harrisburg Medical Center does not discriminate in the provision of services to an individual based upon the individual's race, color, sex, national origin, disability, religion, age or sexual orientation.

II. DEFINITIONS

ABN: Advanced Beneficiary Notice

AGB: amounts generally billed for emergency or other medically necessary care to individuals who have insurance coverage

Application Period: An individual may apply for Healthcare Assistance by completing the Healthcare 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.

Assignment of Benefits: Language present on an insurance card indicating that by accepting the insurance plan for payment at the time of service we are agreement to all of the insurance plan's terms and to accept whatever reimbursement they deem to be acceptable.

Bill: HMC utilizes data mailers and statements to inform patients of the status of their account; for the purpose of this policy these items are not considered a bill

Civil union: a legal relationship between 2 persons, of either the same or opposite sex, established

pursuant to the Illinois Religious Freedom Protection and Civil Union Act

Covered services: emergent or medically necessary

ECA: Extraordinary Collection Actions

Family: 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. According to the Internal Revenue Service rules, if the individual is allowed to claim someone as a dependent on their tax return, they will be considered a dependent for purposes of the provision of Healthcare Assistance.

Federal Poverty Guidelines: the Federal Poverty Guidelines published annually by the U.S. Department of Health and Human Services

Financial Counselor: HMC employee who assists patients with resolution of their financial responsibility including Healthcare Assistance

Financially Indigent: an uninsured person or underinsured person who does not have the ability to pay for services rendered

FPL: Federal Poverty Level

HAP ADD-ON Acct: refers to account(s) that are identified while a HAP application is in the review process, the original application has been final approved and accounts were not on the original HAP worksheet

Healthcare Assistance Application: an application which allows for the collection of information for Healthcare Assistance consideration

Healthcare Assistance Program (HAP): financial assistance provided to HMC patients who meet Financially Indigent, Medically Indigent or Hospital Uninsured Patient Discount Act criteria

Healthshare Plans: Medical cost sharing organizations where members make monthly payments into a shared pool. When a member incurs a qualified medical expense, the claim is reimbursed from the pool. Healthshare plans are NOT insurance, and are not governed by state or federal insurance regulations

HMC: Harrisburg Medical Center

Homeless: 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. Or individual, who doesn't have a stable, long term place to stay, lacks a fixed, regular and adequate night-time residence or resides in a Homeless Shelter

Hospital Information System: computer related software used to register or a scan information received or printed on behalf of a patient

Hospital Uninsured Patient Discount Act: HMC is required to provide discounts for uninsured

Illinois residents with family income less than 300% FPL for hospital inpatients and outpatients; discount is 100% minus 135% of cost utilizing the ratio of cost to charges from worksheet C, Part I from the most recent filed cost report

Illinois Resident: a person who lives in Illinois and who intends to remain living in Illinois indefinitely

Insured Patient: 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.

Judicci: a program utilized to search for pertinent information regarding estate claims

Medi: a Medicaid Eligibility system

Medicaid Eligible: a person who is deemed eligible for medical benefits as determined through the state of Illinois Medical Management and evident by Recipient Identification Number (RIN)

Medically Indigent: refers to a patient whose hospital bills(s), after application of Financial Indigent criteria, exceeds a specific percentage of the patient's annual income and who is not required to pay the remaining balance of their bill(s)

Medical Necessity or Medically Necessary: services provided which are reasonable and necessary

Ninety (90) days: the number of days a patient will not be billed or account sent to Bad Debt/ Collections

Party to a civil union: a person who is established a civil union pursuant to the Illinois Religious Freedom Protection and Civil Union Act; party to a civil union means, and is included in any definition to the use of the terms spouse, family, immediate family, dependent, next of kin, and other terms that denote the spousal relationship

PFS: Patient Financial Services

PFS Representative: HMC employee who works in PFS Department and obtains documentation required for processing Presumptive Eligibility

Presumptive Eligibility: the criterion used to deem a patient eligible for financial assistance based on the guidelines set forth in this policy

Scrutiny: for the purposes of this policy, scrutiny means a completed Healthcare Assistance application is not required

SIH: Southern Illinois Healthcare

Total yearly income: the sum of the yearly gross income

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Uninsured patient: a patient of a hospital who is not covered under a policy of health insurance and is not a beneficiary under a public or private health insurance, health benefit or other health coverage program, including high deductible insurance plans, workers compensation, accident liability or other third party liability

III. RESPONSIBILITIES

1. All staff is required to follow the guideline established within this policy with regard to the completion and processing of all healthcare assistance procedures

IV. EQUIPMENT/MATERIALS

1. Hospital Information System

V. PROCEDURE

1. The Healthcare Assistance Policy (HAP) applies to Harrisburg Medical Center and all the hospital owned clinics, hospital employed providers or independent contracted providers whose services are billed by HMC. A list of providers is available at www.harrisburgmc.com or upon request to the Financial Counselor.
2. Providers delivering care in the hospital, which are not covered by the HAP, 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 at www.harrisburgmc.com or upon request to the Financial Counselor.
3. This HAP applies to all emergency and other medical necessary care provided for the diagnosis and treatment of illness or injury to insured and uninsured patients.
4. Commitment to Provide Emergency Medical Care
    1. HMC provides, without discrimination, care for emergency medical conditions to individuals regardless of whether they are eligible for assistance under this HAP policy.
        A. HMC Hospitals will not engage in actions that discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment for emergency medical conditions or by permitting debt collections activities that interfere with the provision, without discrimination, of emergency medical care.
        Emergency medical services, including emergency transfers, pursuant to EMTALA, are provided to all HMC patients in a non-discriminatory manner, pursuant to HMC's EMTALA policy.
5. The HAP does not apply to certain services such as:
    1. Services which are deemed elective in nature, cosmetic, priced at retail levels, or deemed not

medically necessary in nature including but not limited to 1) Botox, 2) Prescription medicine administered in a medically supervised healthcare setting for treatment of resistant depression, such as but not limited to Spravato, 3) Specialty lens implanted during cataract surgery

2. Accounts where treatment provided is related to or the subject of litigation, settlement, award, or any other type of legal action

3. Accounts that have not had other avenues of payment exhausted

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

7. Reservation of Rights:

    1. HMC reserves the right to limit or deny financial assistance at the sole discretion of HMC.

    2. Complaints or concern with the uninsured patient discount application process or hospital financial assistance process may be reported to the Health Care Bureau of the Illinois Attorney General at www.illinoisattorneygeneral.gov or (877)305-5145.

8. Patient Notification & Signage

    1. Each departments listed will be responsible and accountable for the following:

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

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

        C. Making copies of the Healthcare Assistance application and Plain Language Summary readily available. See Example 2 - Healthcare Assistance Program Application

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

    2. Appropriate signage will be posted in the hospital to create awareness of the HAP. 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 Healthcare Assistance program shall also be placed in these areas.3

    3. Information about the HAP and application process shall be posted at http://www.harrisburgmc.com along with a copy of the HAP, Application, Income Guidelines and Plain Language Summary.

    4. The billing statement for guarantors shall contain a statement regarding how to obtain a copy of an itemized bill and how to apply for Healthcare Assistance.

9. Financial Counselors Responsibilities:

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

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

3. Screening, reviewing, documenting and otherwise preparing applications for processing.
4. Notifying the applicant in writing of the allowance decision.
5. 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.

10. Application Guideline

    1. An individual may apply for Healthcare Assistance in the Application Period.
    2. The applicant has 90 days to return the Healthcare Assistance Application and all required documentation.
        a. HMC will accept a copy of a patient's Healthcare Assistance application submitted to SIH with all required documentation.
    3. An applicant for Healthcare Assistance under this HAP must apply for all eligible funds from local, state, or federal programs before a determination of eligibility.
    4. 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.
    5. The Healthcare 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.
    6. A party to a civil union is entitled to the same legal obligations, responsibilities, protections, and benefits as are afforded or recognized by the law of Illinois to spouses, whether they derive from statute, administrative rule, policy, common law, or any sources of civil and criminal law.
    7. The applicant will be asked to provide proof of gross family income. Following is a list of criteria used to establish income:
        A. 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;
        B. Noncash benefits (such as food stamps and housing subsidies) do not count as income;
        C. Determined on a before-tax income basis (i.e. gross income);
        D. Excludes capital gains or losses;
        E. If a person lives with family, includes the income of all family members

8. 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.

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

   B. 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.

   C. 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:

      1. 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.

      2. 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.

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

      4. Prepaid expenses will be excluded.

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

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

   D. 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.

   E. 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.

   F. A Healthcare Assistance Application received after the Application Period cannot be considered for Healthcare Assistance.

   G. If an applicant has been previously approved for Healthcare Assistance and receives additional services which qualify for Healthcare 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.

9. Evaluation Guidelines

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

    2. 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 as financially indigent.

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

        B. An applicant qualifies for a partial allowance if their income is between 200% and 600% of FPG (i.e. sliding scale) for services provided at the hospital.

        C. See Example 1 - Income Guidelines.

    3. To be considered medically indigent patient amount owed after application of the financially indigent adjustment must not exceed twenty five (25) percent of the patient annual income.

    4. Applications for patients that have been registered self-pay due to assignment of benefit language on the card and/or identified with a non-traditional healthshare/Medishare plan will be processed as normal. Allowances will be applied after documentation is received such as payment, EOB or written statement of no payment on letterhead from non-traditional healthshare/Medishare plan.

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

        A. Homelessness

        B. Deceased with no estate

        C. Mental incapacitation with no representative.

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

        E. 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

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

        G. Incarceration in a penal institution

    6. Applicants who are eligible for Healthcare 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.

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A. The hospital has a written policy, HB-PI-002: Patient Fair Billing and Collections, which contains the AGB. The public may obtain information about the AGB calculation(s) and HB-PI-002: Patient Fair Billing and Collections 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.

B. For the purposes of an insured applicant eligible for Healthcare 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.

7. 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.

8. 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:

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

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

   C. Commence a civil action against the individual.

   D. 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.

9. The following thresholds apply to Healthcare Assistance Applications:

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

   B. Applications over $2,500 must be approved by the Director of Patient Financial Services

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

   A. If the Healthcare 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.

   B. 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.

C. 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.

D. 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 Healthcare Assistance based on their change in financial status if within the Application Period.

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

10. Hospital Uninsured Patient Discount Act - applies to Hospital patients only

    1. 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 20% of annual gross family income for those who meet the eligibility criteria and do not have significant assets. See separate policy Discounts to Uninsured Hospital Self-Pay Patients, HB-PI-001

11. COVID-19 Pandemic During the Public Health Emergency

    1. 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.

    2. 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.

        A. 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.

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

        A. Hospital and clinic charges up to $4,999 will be 100% HAP allowance.

        B. Charges greater than $4,999 will be reviewed for the following options:

            1. Eligibility for Illinois Medicaid for medical benefits,

            2. Submission of claim to the HFS Uninsured Testing Program as long as funds are available. If no funds are available charges will be 100% allowance,

            3. Submission of claim to HRSA Uninsured Programs long as funds are available. If no funds are available charges will be 100% allowance.

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

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D. 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% HAP 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% HAP allowance and a statement sent to the guarantor for the remaining self-pay balance.

VI. DOCUMENTATION

1. Collection activities, such as bills, phone call, inquires, EOBs, Healthcare Assistance documentation are documented in the account notes or scanned into the Hospital Information System.

VII. CHARGES

NA

Attachments

Example 1 - HAP Income Guidelines.pdf

Example 2 - Healthcare Assistance Program Application.pdf

Approval Signatures

Step Description	Approver	Date
	Debbie Emery: Corporate Regulatory Coordinator	3/28/2022
	June Hayes: CFO / VP	3/24/2022
	Jennifer Durham: Director of Patient Accounts	3/22/2022

Older Version Approval Signatures

	Jennifer Durham: Director of Patient Accounts	5/19/2021