MaineHealth

Patient Financial Services Policy

POLICY: **FREE CARE POLICY**

PURPOSE:
It is the policy of MaineHealth (MH) to provide financial assistance to patients who qualify through the guidelines established in this document. Under Maine law, no hospital shall deny services to any Maine resident solely because of the inability of the individual to pay for those services. Every hospital is required to adopt and adhere to a free care policy that provides for a determination of inability to pay, defines the service to be provided as free care, and takes into account other sources of payment for care, consistent with the standards established in Chapter 150 of the governing rules of the Maine Department of Health And Human Services, Office of MaineCare Services.

MH provides full free care to all patients at 200% of the Federal Poverty Guidelines. New Hampshire residents who receive care at Memorial Hospital and/or other associated MaineHealth physician practices may also qualify for the free care program.

All MH hospitals and associated physician practices have adopted the following policy with respect to Free Care for all its providers.

POLICY:

I. INCOME GUIDELINES

A. Definitions. For purposes of this Chapter, the following definitions shall apply:

(1) **Family.** A family is a group of two or more persons related by birth, marriage or adoption who reside together and among whom there are legal responsibilities for support; all such related persons are considered as one family. (If a household includes more than one family and/or more than one unrelated individual, the income guidelines are applied separately to each family and/or unrelated individual, and not to the household as a whole.)

a) Under this policy, registered domestic partners are considered as a family unit.

(2) **Family Unit of Size One.** In conjunction with the income guidelines, a family unit of size one is an unrelated individual, that is, a person of 15 years old or over who is not living with any relatives. An unrelated individual may be the sole occupant of a housing unit, or may be residing in a housing unit (or in group quarters such as a rooming house) in which one or more persons also reside who are not related to the individual in question by birth, marriage, or adoption.

(a) Under this policy, adult students (18 or older) are considered a family of one, even if they are still living with their parents.

(3) **Income.** Income means total annual cash receipts before taxes from all sources except as provided in subparagraph (b) below.

(a) Income includes:

(i) money wages and salaries before any deductions,

(ii) net receipts from non-farm or farm self-employment (receipts from a person's own business or from an owned or rented farm after deductions for business or farm expenses);

(iii) regular payments from social security, railroad retirement, unemployment compensation, workers' compensation, strike benefits from union funds, veterans' benefits;

(iv) public assistance including Temporary Assistance to Needy Families, Supplemental Security Income, and General Assistance money payments;

(v) training stipends;

(vi) alimony, child support, and military family allotments or other regular support from an absent family member or someone not living in the household;

(vii) private pensions, government employee pensions, and regular insurance or annuity payments;

(viii) dividends, interest, rents, royalties, or periodic receipts from estates or trusts; and

(ix) net gambling or lottery winnings.

(b) Income does not include the following:

(i) capital gains;

(ii) any liquid assets, including withdrawals from a bank or proceeds from the sale of property;

(iii) tax refunds;

(iv) gifts, loans, and lump-sum inheritances;

(v) one-time insurance payment or other one-time compensation for injury;

(vi) non-cash benefits such as the employer-paid or union paid portion of health insurance or other employee fringe benefits;

(vii) the value of food and fuel produced and consumed on farms and the imputed value of rent from owner occupied non-farm or farm housing; and

(viii) Federal non-cash benefit programs, including Medicare, Medicaid, Food Stamps, school lunches, and housing assistance.

Note: Although one-time insurance payments are excluded from income, one-time insurance payments made for coverage of hospital services would limit the availability of free care to bills not covered by such payments. See subparagraph IV (B) (1) (b).

(4) **Resident of Maine.** The term "Resident of Maine" refers to an individual living in the state voluntarily with the intention of making a home in Maine. An individual who is visiting or is in Maine temporarily is not a resident. Proof of residency will be requested as part of the application process.

(5) New Hampshire patients who have received services at Memorial Hospital or at an associated physician practice could qualify for free care. MH will follow the same term as described above for a Resident of Maine.

B. Inability to Pay. A person is unable to pay for hospital services when the family income of that person, as calculated by either of the following methods is not more than the applicable income guidelines set forth in subsection C, (if one method does not apply, the other must be applied before determination of ineligibility is made):

(1) Multiplying by four the person's family income for the three months preceding the determination of eligibility; or

(2) Using the person's actual family income for the 12 months preceding the determination of eligibility.

C. Income Guidelines. Under State of Maine regulations, hospitals are required to provide full free care for individuals at 150% of the Federal Poverty Level Guidelines (FPL). MH recognizes that there is a legitimate need to provide additional discounts to people whose annual income may exceed the Federal Poverty Guidelines, but who still lack the ability to pay for services. To that end, MH will provide additional Free Care discounts as stated below. The following income guidelines shall be used in determining whether a person is unable to pay. These income guidelines will be updated every year.

MH will use the current Federal Poverty Guidelines as published in the Federal Register, and will provide Full Free Care for individuals whose income is equal to or less than 200% of the Federal Poverty Guidelines. The current MH Free Care guidelines are listed in Attachment 1 of this policy. MH income guidelines exceed the Department of Health and Human Services requirement.

II. SERVICES COVERED

MH will provide free care for medically necessary inpatient and outpatient services. Only necessary medical care is given as Free Care. MH will follow The Centers for Medicare and Medicaid Services (CMS), Local Medical Review Policies or National Coverage Determinations to determine medical necessity. Medical Necessity can also be determined by the ordering physician, or by the applicant's non-governmental health insurance company. The Free Care program may cover necessary preventative services in the outpatient setting.

Excluded/Limited Services:

1. Cosmetic Surgery, a procedure performed for the sole purpose of improving the appearance of the patient (excluding reconstructive surgery) is not covered by Free Care.
2. Bariatric Surgery is covered by Free Care only if the physician provides a written statement of medical necessity.
3. Dental Surgery, a procedure performed for the sole purpose of removing infected or impacted teeth, is covered by Free Care only if the physician provides a written statement of medical necessity.
4. Procedures related to infertility are not covered by Free Care.
5. Procedures related to sterilization are covered by Free Care only if the physician provides a written statement of medical necessity.

III. NOTICE OF AVAILABILITY OF FREE CARE

A. **Plain Language Summary.** MH hospitals and physician practices shall post notices of the availability of Free Care in locations within the facility at which members of the public generally transact business with the hospital or present themselves to receive or request

hospital services, including admitting areas, waiting rooms, business offices, and outpatient reception areas.

B. **Individual Notice.** With respect to inpatient services, MH hospitals and physician practices shall provide individual written notice of the availability of Free Care before discharge. With respect to outpatient services, each hospital shall either accompany the patient's bill with a copy of an individual notice of the availability of Free Care or shall provide a copy of the individual notice at the time service is provided.

C. Content of Notice.
The posted and individual written notice is found in Attachment 2 to this policy.

D. **Communication of Contents.** Hospitals and physician practices shall make reasonable efforts to communicate the contents of the written notice to persons reasonably believed to be unable to read the notice. Translations of the free care documents can be found at the MH website (mainehealth.org) under the financial assistance tab.

IV. DETERMINATION OF QUALIFICATION

A. Application

(1) MH shall provide an opportunity for each person seeking Free Care to make application on forms provided by MH hospitals.

(2) MH will require an applicant to furnish any information that is reasonably necessary to substantiate the applicant's income or the fact that the individual is not covered by insurance or eligible for coverage by state or federal programs of medical assistance when processing approvals.

a. See Attachment 3 for required documentation

(3) Free Care applications will be processed by financial counselors of the Consolidated Business Office (CBO) or designated staff at each facility.

B. Determination

(1) Upon receipt of an application, the CBO or designated staff shall determine that an individual seeking free care qualifies for such care if:

(a) the individual meets the income guidelines specified in Section I;

(b) the individual is not covered by any insurance nor eligible for coverage by state or federal programs of medical assistance; and,

(c) services received were medically necessary.

(2) If the CBO or designated staff determines that the individual seeking Free Care meets the income guidelines but is covered by insurance or by state or federal programs of medical assistance, it shall determine that any amount remaining due after payment by the insurer or medical assistance program will be considered free care.

(3) MH will allow the determination of qualification for outpatient free care services to remain valid for up to six months for subsequent emergent or medically necessary care following the date of determination. This will include all outstanding receivables including those at bad debt agencies unless a payment has been applied on the account. A change in financial situation or the addition of third party payer eligibility may alter the approval period and require further review.

A determination of qualification for inpatient Free Care services shall be made with each admission.

C. Deferral of Determination

(1) Under the conditions specified in paragraphs (2) and (3) below, a determination of qualifications for Free Care may be deferred up to 60 days, for the purpose of requiring the applicant to obtain the present evidence of ineligibility for medical assistance programs or to verify that the services in question are not covered by insurance.

(2) If an applicant for Free Care, who meets the income guidelines in section

I. and who is not covered under any state or federal program of medical assistance, meets any of the following criteria, qualification for Free Care shall be deferred:

(a) age 65 or over;

(b) blind,

(c) disabled;

(d) an individual is a member of a family in which a child is deprived of parental support or care due to one of the following causes, and the individual's income is less than the guidelines in section I:

(i) death of a parent;

(ii) continued absence of the parent(s) from the home due to incarceration in a penal institute, confinement in a general, chronic or specialized medical institution, deportation to a foreign country, divorce, desertion or mutual separation of parents, or unwed parenthood;

(iii) disability of a parent; or

(iv) unemployment of a parent who is the principal wage earner.

(3) If an individual does not meet any of the criteria specified in (2) above, but the hospital is unable to determine the coverage of the individual and has a reasonable basis for believing that the individual may be covered by insurance or eligible for federal or state medical assistance programs, it may defer the determination concerning Free Care.

D. Content of Favorable Determination.

A determination that an applicant qualifies for Free Care must indicate:

(1) That MH hospitals will provide care at no or reduced charge;

(2) The date on which the services were requested;

(3) The date on which the determination was made; and

(4) The date on which services were or will be first provided to the applicant.

(5) Any previous outstanding balances for MH hospitals will be waived upon approval of financial assistance.

(6) Outpatient services will be covered for a six month period moving forward from the approval date.

(7) Patients receiving Inpatient services will need to re-apply for Free Care if their previous approval was more than 30 days from the current admission. If a patient is admitted inpatient within 30 days from the approval of outpatient Free Care, they will be asked to sign an attestation form confirming their income has not changed since their previous application.

(8) Patients receiving Outpatient services, and who have been deemed eligible under the Free Care policy or have been denied Free Care, may be re-evaluated upon request if the patient has experienced a change of income during their six month coverage period. Such patients will be required to re-apply under the program with updated income information.

E. Reasons for Denial

MH CBO or designated staff shall provide each applicant who requests Free Care and is denied it, a written and dated statement of the reasons for the denial when the denial is made. When the reason for denial is failure to provide required information during a period of deferral under subsection IV (C), the applicant shall be informed that she or he may reapply for Free Care, if the required information can be furnished. Additionally, the notice must state that the patient has a right to a hearing; how to obtain a hearing; and name and telephone number of the person who should be contacted, should the provider/patient have questions regarding the notice.

F. Reasons for Deferral

(1) When an application for Free Care under paragraph IV (C) (2) is deferred, the applicant shall be notified as follows:

A Free Care determination has not yet been made. There is reason to believe that you [the applicant] may be eligible for coverage by state or federal medical assistance programs. If you can show that you are not eligible for coverage by these programs within 60 days of the date of this notice by obtaining a letter or other statement from_____[insert name of state or federal agency to which applicant has been referred], then you will be considered qualified for Free Care. Even if you are eligible for coverage, Free Care will be available for any portions of the bills that medical assistance programs (or any insurance that you have) will not pay.

(2) When an application is deferred under paragraph IV (C) (3), the applicant shall be notified of the reason for deferral, including the basis for the hospital's belief that coverage or eligibility may exist and the nature of the evidence that should be provided to complete the determination. The notice shall be in substantially the form specified in paragraph (1) above and shall include the last sentence of that form.

V. BILLING

A. If an individual has been determined qualified for 100% free care under IV (B) (1), the individual shall not be billed for the services provided.

B. If an individual has been determined qualified for 100% free care under IV (B) (2), the individual shall not be billed for any amount not paid by an insurer or medical assistance program.

C. If you are approved for financial assistance under our policy and your approval does not cover 100% of our charges for the service, you will not be charged more for emergency or other medically necessary care, than the amount generally billed (AGB) to patients having insurance. MH has chosen to use the Look Back Method for calculating the AGB for patients applying for financial assistance. You can find more information related to AGB, by visiting the billing section of our website. AGB information can be found under section, Policies, Billing & Collection Policy. You may also request a free copy of this policy by contacting Patient Financial Services at 207-887-5100, or toll-free at (866) 804- 2499.

D. If an individual's application for free care has been deferred under subsection IV (C), then the individual may be billed for services during the period of deferral.

E. If an individual has been determined qualified for free care under subsection IV (B) or if the determination covering free care has been deferred under subsection IV(C), then no municipality shall be billed under the general assistance program for hospital care provided to that individual.

F. MH will use the following communication attempts to collect on a bill from our guarantors; patient statements, letters and phone calls. Following the MH Billing & Collection policy, at day 130 in this process if there has been no communication with the guarantor on payment of the outstanding amount the account will qualify for referral to our collection agency. A copy of the MH Billing & Collection policy can be found on the MH website at www.mainehealth.org or by calling the customer service department at 207-887-5100 or toll free at (866) 804-2499.

VI. REPORTING AND RECORD KEEPING

A. MH shall maintain records of the amount of Free Care provided in accordance with

the minimum guidelines established in this Policy and the number of individuals to whom it was provided. If a hospital provides free care that is not required by this Policy, the hospital shall maintain separate records of the amount of such care provided and the number of individuals to whom it was provided.

B. Each Maine Hospital shall report to the Maine Department of Health and Human Services (DHHS) as part of its filing of information for purposes of final reconciliation, a summary of the amount of Free Care that was provided in the applicable payment; the amount of Free Care that was not required but was provided in that year; and the number of individuals to whom each type of Free Care (required and not required) was provided.

VII. FILING; APPLICABILITY

A. MH Hospitals are required to file and maintain with DHHS a current copy of its Free Care policy and a current copy of its Plain Language Summary.

VIII. NOTICE OF OPPORTUNITY FOR A FAIR HEARING

A. In accordance with 22 M.R.S.A. §1716, DHHS must grant the opportunity for a fair hearing regarding eligibility for Free Care to:

(1) Any applicant who requests it because his or her claim for Free Care is denied or not acted upon with reasonable promptness, or

(2) Any recipient of care who requests it because he or she believes the hospital has taken an action erroneously.

B. Procedure to Request an Administrative Hearing

An applicant for free care may request an Administrative hearing if he or she is aggrieved by the action that denies the request for free care. The Department may respond to a series of individual requests for a hearing by conducting a single group hearing. The applicant must follow the procedures described in this Section when requesting an administrative hearing from DHHS.

(1) An Administrative Hearing may be requested by an applicant or his/her representative.

(2) Unless otherwise specified in these rules, administrative hearings must be requested within sixty (60) days of the date of written notification to the

applicant of the action the applicant wishes to appeal.

(3) Request must be made by the applicant or his/her representative, in writing or verbally, for a Hearing to the Administrative Hearings Unit, Department of Health and Human Services, 11 State House Station, Augusta, Maine 04333-0011. For the purposes of determining when a hearing was requested, the date of the fair hearing request shall be the date on which the request for a hearing is made is considered the date of request for the hearing. The Administrative Hearings Unit may also request that a verbal request for an administrative hearing be followed up in writing, but may not delay or deny a request on the basis that a written follow-up has not been received.

(4) The Hearing will be held in conformity with the Maine Administrative Procedure Act, 5 M.R.S.A. §8001 *et seq*. and the Department's Administrative Hearing Manual.

(5) The Hearing will be conducted at a time, date and place convenient to hospital and the claimant, and at least twenty (20) days preliminary notice will be given. In scheduling a hearing, there may be instances where the hearing officer shall schedule the hearing location near the claimant or by telephone or Interactive Television System.

(6) The Department, the hospital and the applicant may be represented by legal counsel and may have witnesses appear.

(7) When a medical assessment by a medical authority other than the one involved in the decision under question is requested by the hearings officer, the hospital or the applicant and considered necessary by the hearings officer, it will be obtained at the Department's expense, and forwarded to the applicant or the applicant's representative, the hospital or its representative, and hearing officer allowing all parties to comment.

(8) When the applicant or the hospital or a Department staff person requests a delay, the hearing officer may reschedule the hearing, after notice to all parties.

(9) The decisions, rendered by the hearing authority, in the name of DHHS, will be binding upon the Department, unless the Commissioner directs the hearing officer to make a proposed decision reserving final decision making authorization to him or herself.

(10) Any person who is dissatisfied with the hearing authority's decision has a right to judicial review under Maine Rules of Civil Procedure, Rule 80C.

C. Dismissal of Administrative Hearing Requests

If any of the following circumstances exist, the Office of Administrative Hearings may dismiss the request for an administrative hearing.

(1) The claimant withdraws the request for a hearing.

(a) The claimant, without good cause, abandons the hearing by failing to appear.

(b) The sole issue being appealed is one of federal or state law requiring an automatic change adversely affecting some or all applicants for free care.

(2) Where an applicant's request for an administrative hearing is dismissed, the Office of Administrative Hearings shall notify the individual of his or her right to appeal that decision in Superior Court.

D. Corrective Action

The hospital must promptly make corrective action when appropriate, retroactive to the date an incorrect action was taken by the hospital if:

(1) The hearing decision is favorable to the applicant; or

(2) DHHS decides in the applicant's favor before the hearing.

IX. MEDICAL INDIGENCE AND PRESUMPTIVE ELIGIBILITY

MH recognizes that there may be instances where a patient would not qualify for Free Care under this policy and yet still be legitimately unable to pay for the services provided. To that end, MH has created two additional categories of adjustment, Medically Indigent and Presumptive Eligibility.

A. Medical Indigence

There are three basic categories of Medically Indigent patients considered in this Policy. The first category includes those patients who qualify for Free Care based on their income, but who do not otherwise meet the requirements of Chapter 150. Some examples of this category include:

- Patient is not a Maine or New Hampshire resident
- Patient is homeless
- Patient was in a coverable group but did not supply a denial notice from DHHS
- Services were not medically necessary, but deemed medically appropriate by provider

The second category includes those patients who do not meet the Free Care guidelines based on their gross income, but their net income does not enable them to meet their payment obligations for their medical bills.

Both categories of patients above will be approved for adjustment by supervisory or management staff in the Patient Financial Services Department or applicable CBO designated staff, upon recommendation by collection or customer service staff. Completion of a Financial Questionnaire accompanied by income and expense information is required to validate the need for an adjustment under this section. An asset test may be applied if deemed appropriate by MH.

A third category of medically indigent patients , those classified as may include Out of State Cancer patients, can be approved for Free Care on a case by case basis under this Policy above. Out of state patients who are participating in the Cancer Care program and require necessary cancer medication for treatment will be considered by MH for Free Care. This Free Care approval will be entered into the EHR system with effective and expiration dates to ensure that patients who qualify for Free Care will also receive their required medications at no cost.

B. Presumptive Eligibility

Presumptive eligibility is intended for those patients who never completed a Free Care application, but the Patient Financial Services department has sufficient information to determine that the patient would qualify for Free Care if they applied.

Examples include the following:

- By using the Healthcare Income Predictor 2.0 software, determine eligibility for financial assistance based on the income score returned.
- Patient is homeless, and did not complete an application
- Patient is covered by an out of state Medicaid plan that the provider is not credentialed with, and the patient's balance does not justify completion of the burdensome paperwork associated with credentialing
- Patient is covered by State of Maine MaineCare program or New Hampshire Medicaid, presumptive eligibility will be applied for services not covered prior to MaineCare enrollment.
- Patient is covered by CarePartners program, presumptive eligibility will be applied for services not covered prior to CarePartners enrollment.
- Patient is incarcerated and has no assets
- Prior qualifications for free care are not used to determine if someone is eligible for presumptive eligibility.

Consistent with the section on Medical Indigence, Presumptive Eligibility patients will be approved for adjustment by supervisory or management staff in the Patient Accounts Department.

X: ASSISTANCE FOR STATE & FEDERAL PROGRAMS

MH has developed a program to assist its self-pay patients in applying for State or Federal programs that may help cover the cost of hospital or physician services. This program includes a visit to all self-pay inpatients and select outpatients based on MH referrals to determine their eligibility for State and/or Federal programs. MH may assist in the application process for new born babies and qualifying them for the State of Maine MaineCare (Medicaid) program or for Memorial Hospital and associated physician practice patients to the State of New Hampshire Medicaid program. Patients who apply for Free Care who have been an inpatient at MH will be referred to DHHS for a determination of eligibility for MaineCare (Medicaid). If it is determined that a patient will not qualify for any State or Federal assistance that determination will be accepted as a DHHS denial and MH will process the patients Free Care application.

XI: MARKETPLACE PLANS

With the Affordable Care Act comes a requirement for our patients to have healthcare coverage either through an employer sponsored plan, private purchase plan or by applying through the Health Insurance Marketplace. MH has available resources to assist our patients through the process of applying for Marketplace plans. Patients can contact our CarePartners team at 877-626-1684 for assistance.

Patients who apply for Free Care who have been an inpatient at any MH hospital will be referred to DHHS for a determination of eligibility for MaineCare (Medicaid) or New Hampshire Medicaid for Memorial Hospital patients. If the patient can supply a copy of the Health Insurance Marketplace Eligibility Notification showing they would not be eligible for MaineCare, we will accept this as a DHHS denial and the MH staff will process the patients Free Care application.

XII: CONTACT INFORMATION FOR FINANCIAL ASSISTANCE

An individual can apply for Free Care at the MH Financial Counseling office at 662- 1949 or toll-free at (800) 619-9715, or by contacting the Patient Financial Services office at 887- 5100 or toll-free at (866) 804-2499. The Free Care application and this policy can also be found on our website under the billing section.

For alternative financial resources, patients may contact Care Partners. CarePartners coordinates the provision of donated healthcare services for low-income, uninsured residents in five Maine counties (Cumberland, Lincoln, Waldo,York and Kennebec). The program, a partnership between MH, physicians, hospitals and other healthcare providers, helps community members who do not otherwise qualify for public or private healthcare coverage programs get comprehensive, medically necessary healthcare. For more information regarding

CarePartners please call toll-free at 877-626-1684.

XIII: PHYSICIAN SERVICES COVERED UNDER FINANCIAL ASSISTANCE

All physician services provided by MH physician groups will be covered under the free care program. Some providers of service are not affiliated with MH and may not accept our determination of free care Those providers could include the following: Spectrum Medical Group (Anesthesia, Pathology & Radiology), InterMed physicians and other private physician practices or groups.

REVIEW: Institutional Policy Committee: _____

Sponsoring Director:_____ **Date**: _____
Sr. Director CBO

VP/AVP Approval:_____ **Date:** _____
VP of Revenue Cycle

Attachment 1

MaineHealth Free Care Guidelines 2020		
	Maine DHHS Chapter 150 Requirement	
Persons in Family	**150% of FPL**	**200% of FPL**
1	$19,140	25,520
2	$25,860	34,480
3	$32,580	43,440
4	$39,300	52,400
5	$46,020	61,360
6	$52,740	70,320
7	$59,460	79,280
8	$66,180	88,240
For each additional person, add	$6,720	8,960
Discount Applied:	100%	100%

Attachment 2

NOTICE
MEDICAL CARE FOR THOSE WHO CANNOT AFFORD TO PAY

Maine law requires that free medical care must be provided to Maine residents with income less than 150% of the federal poverty level. MaineHealth provides full free care to all patients at 200% of the poverty level. New Hampshire residents who receive care at Memorial Hospital and/or other associated MaineHealth physician practices may also qualify for the free care program.

MaineHealth Free Care Guidelines 2020		
	Maine DHHS Chapter 150 Requirement	
Persons in Family	**150% of FPL**	**200%**
1	$19,140	25,520
2	$25,860	34,480
3	$32,580	43,440
4	$39,300	52,400
5	$46,020	61,360
6	$52,740	70,320
7	$59,460	79,280
8	$66,180	88,240
For each additional person, add	$6,720	8,960
Discount Applied:	100%	100%

You will be asked if you have insurance of any kind to help pay for your care. You may also be asked to show that insurance or a government program will not pay for your care.

Charges Will Not Exceed Amounts Generally Billed to Medicare

If you are approved for financial assistance under our policy and your approval does not cover 100% of our charges for the service, you will not be billed more for emergency or other medically necessary care, than the amount generally billed to patients having insurance.

Only necessary medical care is given as free care. If you do not qualify for free medical care, you may ask for a fair hearing. We will tell you how to apply for a fair hearing.