**POLICY:**

This policy establishes guidelines for free care at CMC, including minimum income guidelines to be used in determining whether individuals are unable to pay for hospital services. This policy sets forth procedures for notifying patients of the availability of free care, determining who is qualified for such care, and annually reporting the quantity of free care provided, as required by the guidelines developed under the Hospital Finance Rules, Chapter 150, Section 1 Hospital Free Care Guidelines.

1.01 OBLIGATION TO PROVIDE SERVICE AND ADOPT POLICY

A. Cary Medical Center shall not deny any medically necessary services to any Maine resident solely because of the inability of the individual to pay for those services. CMC, via this policy, provides for a determination of the inability to pay, defines the services to be provided as free care taking into account other sources of payment for care, consistent with the standards established in The Hospital Finance Rules.

B. For purposes of this policy, "free care" means service provided without expectation of payment from, or on behalf of, the individual receiving the hospital services.

C. This policy applies to:
   a. Maine Residents receiving emergency and other medically necessary care as determined by the clinical judgment of the provider without regard to the financial status of the patient, and who meet the requirements outlined below.
   b. Non-Maine Residents seeking emergency care and who meet the requirements outlined below.

D. Financial Assistance does not:
   a. Provide health insurance
   b. Act as a substitute or supplement for health insurance
   c. Guarantee benefits

1.02 INCOME GUIDELINES

A. Definitions. Relative to this policy, the following definitions shall apply:

(1) Family. A family is a group of two or more persons related by birth, marriage, adoption, or other who reside together and among whom there are legal responsibilities for support; all such related persons are considered members of one family.
   a. If you file taxes or you are claimed as a dependent, your household is you and anyone else listed on the tax return.
   b. If you do not file taxes and are not claimed as a dependent by anyone else, your household is you, your spouse, and your children that live with you.
   c. For divorced/separated/joint custody parental relationships – dependent

children may only be listed on one program application.

d. Financially co-dependent unmarried couples including registered domestic partners living together with mutual children will be counted as one household.
e. All married couples will be counted as a household.

(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 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, worker's 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) income from 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.

(4) <u>Resident of Maine</u>. 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.

A. <u>Inability to pay.</u> 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 month's (e.g., 12 weeks income divided by twelve (12) weeks multiplied by fifty-two (52) weeks) preceding the determination of eligibility; or

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

B. Income Guidelines:

In accordance with Chapter 150, Hospital Finance Rules, Section 1, Cary Medical Center will provide Medically Necessary Free Care to residents of Maine whose income falls below the income guidelines in Attachment "A". Cary Medical Center establishes its income eligibility guidelines for free care based on one hundred ninety percent (190%) of the Federal Poverty Level Guidelines (FPL).

| 0-190% | 191-200% | 201-210% |
|---|---|---|
| 100% write off | 75% write off | 50% write off |

If you believe you qualify for Free Care, please apply at:

The Financial Counselor's Office: (207) 498-1617
Toll Free: 1-800-858-2279, ext. 1617
billinghelp@carymed.org
www.carymedicalcenter.org

Before providing free care, Cary Medical Center will ask for information about your income and also ask you to show that insurance or a government medical assistance program will not pay for your care.

The FPL is issued annually by the U.S. Department of Health and Human Services. Each year's FPL is available on the Internet at http://aspe.hhs.gov/poverty. An individual can also obtain a copy of the current FPL by contacting the individual's local Department of Health and Human Services office: by calling 1-800-321-5557, ext. 79368 or 1-207-287-9368; or by writing to:

Office of MaineCare Services
Division of Policy
11 State House Station
Augusta, Maine 04333-0011

1.03 SERVICES COVERED

Cary Medical Center will provide Free Care for medically necessary inpatient and outpatient hospital services.

1.04. NOTICE OF AVAILABILITY OF FREE CARE

A. Posted Notice. Notices of the availability of free care will be posted in locations within the hospital at which the 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, individual written notice of the availability of Free Care will be given to each patient upon admission or in the case of emergency admission, before discharge. With respect to outpatient services, notice of the availability of Free Care will be provided at the time service is provided.

C. Communication of Contents: Cary Medical Center will make reasonable efforts to communicate the contents of the written noticed to persons reasonably believed to be unable to read the notice.

1.05 DETERMINATION OF QUALIFICATION

A. Application.

(1) Cary Medical Center will provide an opportunity for any patient and/or authorized representative seeking Free Care to complete an application provided by Cary Medical Center.

(2) Cary Medical Center may 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.

(3) Patient must be notified of the availability of financial assistance within 120 days of the post-discharge bill date, and the patient has 240 days from the post-discharge bill date to apply for financial assistance.

B. Determination

(1) Upon receipt of an acceptably completed application, Cary Medical Center shall determine that an individual seeking free care qualifies for such care if:

(a) the individual meets the income guidelines specified in Section 1.02;

(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 it is determined 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) Cary Medical Center 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 the patient's financial situation (e.g., income) or the addition of a third party payor may alter the previously approved financial assistance status.

(4) A determination of qualification for inpatient Free Care services shall be made upon application for each admission, unless the admission in question occurs within thirty (30) days of a prior approval of inpatient financial assistance.

(5) Example of approval/expiration timeframes:

| APPROVED IN | EXPIRES IN |
|---|---|
| January | July |
| February | August |

(6) MaineCare Determination Timeframe - Maine Care (DHHS) must make a determination of eligibility within forty-five (45) calendar days of receiving a completed application. If an application is missing required documents, the applicant should get a request from MaineCare to provide the documents, and then has ten (10) days (after the notice is required) to submit the documents. If DHHS does not determine eligibility within forty-five (45) days due to their own delays, they must send the applicant a temporary MaineCare coverage card to use until DHHS renders a final decision. If DHHS later denies eligibility for MaineCare, the patient will not have to repay DHHS for services received while using the temporary card, if approved for financial assistance.

(7) Presumptive Eligibility – CMC may refer to or rely on external sources and/or other program enrollment resources in the case of patients lacking documentation that supports eligibility or individual circumstance. CMC may provide free or discounted services if a patient is/has:

a) Homeless;
b) Deceased and without an estate;
c) Filed for bankruptcy;
d) A minor seeking confidential services in the state of Maine;
e) Patient liability in excess of 25% of their annual income
f) One time personal circumstance such as: loss of home due to fire or natural disaster; temporary financial loss due to lay-off or unemployment; recent divorce resulting in loss of insurance coverage and/or second income; or death of spouse resulting in loss of primary income.

C. Deferral of Determination.

(1) Under the conditions specified in paragraphs (2) and (3) that follow, a determination of qualification for free care may be deferred for up to 60 days, for the purpose of requiring the applicant to obtain and 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 1.02 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 1.02:

(i) death of a parent;

(ii) continued absence of the parent (s) from the home due to incarceration in a penal institution, 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

(iii) 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 the hospital will provide care at no charge or to receive care at 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 due to Cary Medical Center will be waived upon the determined level of approved financial assistance.

(6) The patient must notify Cary Medical Center if their qualifying status has changed (e.g., income change, family size change, change in employment status). The patient will be required to provide proof of the change

E. Reasons for Denial. Cary Medical Center will provide each applicant who requests free care and is denied it, in whole or in part, 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 1.05 (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 1.05 (C) (2) is deferred, the applicant shall be notified as follows:

   Free care determination has not yet been made because there is reason to believe that you 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 the Department of Health & Human Services, 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 bill that medical assistance programs (or any insurance that you may have) will not pay.

2. When an application is deferred under paragraph 1.05 (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.

3. The patient may reapply for assistance if they experience a change in income (or other qualifying factor) which will require the patient to apply with updated income information.

1.06 BILLING

A. If an individual has been approved for 100% free care under 1.05 (B) (1), the individual shall not be billed for the services provided.

B. If an individual has been approved for 100% or less free care under 1.05 (B) (2), the individual shall not be billed for any amount paid by an insurer or medical assistance program.

C. If an individual is approved for free care 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 with insurance. The individual will not be charged more than the discounts provided for Medicare and all private health insurers. The current discount applied to amounts generally billed is approximately 50%. AGB information can further be found in our Billing & Collections Policy.

D. If an individual's application for free care has been deferred under subsection 1.05 (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 1.05 (B) or if the determination covering free care has been deferred under subsection 1.05 (C), then no municipality shall be billed under the general assistance program for hospital care provided to that individual.

1.07 NO LESSER COVERAGE ALLOWED

Cary Medical Center has not established policies that limit the availability of free care to individuals who are qualified for free care under the provisions of The Hospital Finance Rules, Chapter 150, Section 1 Hospital Free Care Guidelines.

1.08 REPORTING AND RECORD KEEPING

A. The Financial Counselor's Office will maintain records of the amount of free care provided in accordance with the minimum guidelines established in this policy and of individuals to whom it was provided.

B. Cary Medical Center reports to the Department of Health and Human Services, 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 year in accordance with the requirements of this

chapter; the amount of free care that was not required under this Chapter that was provided in that year; and the number of individuals to whom each type of free care (required and not required) was provided.

1.09 FILING; APPLICABILITY

Cary Medical Center shall file with the Department of Health and Human Services a copy of its free care policy and a current copy of its posted notice of free care, adopted pursuant to the guidelines in this rule.

1.10 NOTICE OF OPPORTUNITY FOR A FAIR HEARING

Mail a copy of the Hospital's Free Care policy to:

Rate Setting Unit
Office of Operations and Support
Department of Health and Human Services
11 State House Station,
Augusta, ME 04333-0011

A. In accordance with 22 M.R.S.A. §1716 the Department 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.

(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 the Maine Department of Health and Human Services, 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 effecting some or all applicants for free care.

(2) Where an applicant's request for an administrative hearing is dismissed pursuant to this Section, 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) The agency decides in the applicant's favor before the hearing.

1.11 PHYSICIAN SERVICES COVERED UNDER FINANCIAL ASSISTANCE

All emergency or medically necessary services provided by Cary Medical Center physicians at Cary Medical Center will be covered under the financial assistance program.

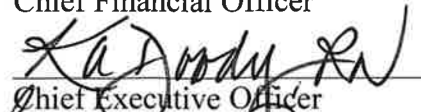
Effective Date: 05/10/1997

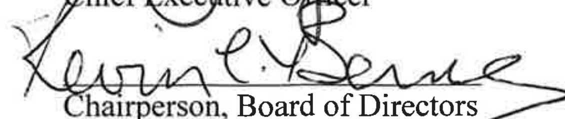
Revised Date: 06/27/2024

Review Date:

Patient Access Manager

Chief Financial Officer


Chief Executive Officer


Chairperson, Board of Directors

Formerly policy number 80-085-007

# MEDICAL CARE FOR THOSE WHO MAY QUALIFY FOR FINANCIAL ASSISTANCE

In accordance with Chapter 150, Section 1 Hospital Finance Rules, Cary Medical Center will provide **Free Care** to residents of the State of Maine whose income falls below the following guidelines:

| | | Percentage of Poverty | | |
|---|---|---|---|---|
| **Federal Guidelines** | **Family Size** | **0-190%** | **191-200%** | **201-210%** |
| | | **100% write off** | **75% write off** | **50% write off** |
| | | | | |
| **$15,060** | **1** | **$28,614** | **$30,120** | **$31,626** |
| **$20,440** | **2** | **$38,836** | **$40,880** | **$42,924** |
| **$25,820** | **3** | **$49,058** | **$51,640** | **$54,222** |
| **$31,200** | **4** | **$59,280** | **$62,400** | **$65,520** |
| **$36,580** | **5** | **$69,502** | **$73,160** | **$76,818** |
| **$41,960** | **6** | **$79,724** | **$83,920** | **$88,116** |
| **$47,340** | **7** | **$89,946** | **$94,680** | **$99,414** |
| **$52,720** | **8** | **$100,168** | **$105,440** | **$110,712** |

***For family units larger than 8, add $5,380 per year for each additional person***

If you believe you qualify for Free Care, please contact:

Financial Counselors' Office, Phone: (207) 498-1617
(800) 858-2279 ext. 1617
Email address: billinghelp@carymed.org

Before providing financial assistance, the hospital will ask for information about your income and ask you to verify that insurance or government medical assistance programs will not pay for your care.

Only services that are medically necessary are provided within our Financial Assistance Program.

Individuals can access our application on our website, www.carymedicalcenter.org, or by visiting our financial counselors' office:

163 Van Buren Rd, St 1
Caribou, ME 04736

If you disagree with the determination, you may ask for a fair hearing. We can explain how to apply for a fair hearing.

The above income guidelines are effective February 5, 2024.

Cary Medical Center is an Equal Opportunity Employer and Provider