



MaineHealth System-Wide Policy

This policy was approved jointly by MaineHealth member organizations and applies to all MaineHealth system members and subsidiaries, including each of the entities below: MaineHealth Corporate, MaineHealth Medical Group, Maine Medical Center-Portland, Maine Medical Center-Biddeford, Maine Medical Center-Sanford, Lincoln Hospital, Franklin Hospital, Mid Coast Hospital, Stephens Hospital, Pen Bay Hospital, Waldo Hospital, Memorial Hospital, Behavioral Health at Spring Harbor (MaineHealth Behavioral Health), MaineHealth Care at Home, MaineHealth CHANS Home Health & Hospice, and NorDx.

Policy Title: *Free Care*

Search Word: *Billing, Collections, Self-pay, Financial Assistance*

Policy Summary:

It is the policy of MaineHealth hospitals, and Memorial Hospital of North Conway N.H. (collectively "MH Hospitals") to provide financial assistance to patients who qualify under the guidelines established in this Policy.

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I. Scope:

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. Other associated MaineHealth physician practices also adhere to this Free Care Policy.

II. Policy Statements:

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. MH Hospitals provide full Free Care to all patients at or below 200% of the Federal Poverty Guidelines.

III. Procedures:

1. Income Guidelines

a. **Definitions.** For the purpose of this Policy, the following definitions shall apply:

- i. **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.)

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

- ii. **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.

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

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

1. Income includes:

- money wages and salaries before any deductions
- 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)
- regular payments from social security, railroad retirement, unemployment compensation, workers' compensation, strike benefits from union funds, veterans' benefits
- public assistance including Temporary Assistance to Needy Families, Supplemental Security Income, and General Assistance money payments
- training stipends

- alimony, child support, and military family allotments or other regular support from an absent family member or someone not living in the household
 - private pensions, government employee pensions, and regular insurance or annuity payments
 - dividends, interest, rents, royalties, or periodic receipts from estates or trusts
 - net gambling or lottery winnings
2. Income does not include the following:
- capital gains
 - any liquid assets, including withdrawals from a bank or proceeds from the sale of property
 - tax refunds
 - gifts, loans, and lump-sum inheritances
 - one-time insurance payment or other one-time compensation for injury
 - non-cash benefits such as the employer-paid or union paid portion of health insurance or other employee fringe benefits
 - 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
 - Federal non-cash benefit programs, including Medicare, Medicaid, Food Stamps, school lunches, and housing assistance
3. 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 subsection 4.a.
- iv. Person: The term “Person” shall mean a Resident of Maine or New Hampshire.
- v. 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.
- vi. Resident of New Hampshire: The term “Resident of New Hampshire” refers to an individual living in the state of New Hampshire voluntarily with the intention of making a home in New Hampshire. An individual who is visiting or is in New Hampshire temporarily is not a resident. Proof of residency will be requested as part of the application process.
- 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 2.3, (if one method does not apply, the other must be applied before determination of ineligibility is made):

- i. Multiplying by four the Person's family income for the three months preceding the determination of eligibility; or
 - ii. 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). MaineHealth 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 to Residents of Maine and New Hampshire 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.
 - i. MaineHealth will use the current Federal Poverty Guidelines as published in the Federal Register and will provide full Free Care to 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.

2. Services Covered

- a. 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 Policy may cover necessary preventative services in the outpatient setting.
 - i. Excluded/Limited Services:
 - 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.
 - Bariatric Surgery is covered by Free Care only if the physician provides a written statement of medical necessity.
 - 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.
 - Procedures related to infertility are not covered by Free Care.
 - Procedures related to sterilization are covered by Free Care only if the physician provides a written statement of medical necessity.

3. 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 1 to this policy.
- d. Communication of Contents: MH 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.

4. Determination of Qualification

- a. Application
 - i. MH shall provide an opportunity for each Person seeking Free Care to make application on forms provided by MH hospitals.
 - ii. 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.
 - iii. Free Care applications will be processed by financial counselors of the Consolidated Business Office (CBO) or designated staff at each facility.
- b. Determination
 - i. Upon receipt of an application, the CBO or designated staff shall determine that an individual seeking Free Care qualifies for such care if:
 - the Person meets the income guidelines specified in Section 1;
 - the Person is not covered by any insurance nor eligible for coverage by state or federal programs of medical assistance This determination will not

be required if the services were provided by facilities or practices participating in the NHSC Loan Repayment Programs.

- services received were medically necessary.
- ii. If the CBO or designated staff determines the Person 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.
 - iii. 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.
 - iv. A determination of qualification for inpatient Free Care services shall be made with each admission.
- c. Deferral of Determination
- i. Under the conditions specified in paragraphs (ii) and (iii) 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.
 - ii. If an applicant for Free Care, who meets the income guidelines in section 1 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; this determination will not be required if the services were provided by facilities or practices participating in the NHSC Loan Repayment Programs.
 - age 65 or over;
 - blind,
 - disabled,
 - a Person 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 Person's income is less than the guidelines in section 1.
 - death of a parent;
 - 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;

- disability of a parent; or
- unemployment of a parent who is the principal wage earner

- iii. If a Person does not meet any of the criteria specified in (ii) above, but the MH 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. This determination will not be required if the services were provided by facilities or practices participating in the NHSC Loan Repayment Programs.

d. Content of Favorable Determination

- i. A determination that a Person qualifies for Free Care must indicate:
- That MaineHealth will provide care at no or reduced charge;
 - The date on which the services were requested;
 - The date on which the determination was made; and
 - The date on which services were or will be first provided to the applicant.
 - Any previous outstanding balances for MH Hospitals will be waived upon approval of financial assistance.
 - Outpatient services will be covered for a six month period moving forward from the approval date.
 - Persons receiving Inpatient services will need to re-apply for Free Care if their previous approval was more than 90 days from the current admission. If a Person is admitted inpatient within 90 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.
 - Persons 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

- i. 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 section 4., the Person 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 Person has a right to a hearing; how to obtain a hearing; and name and telephone number of the individual who should be contacted, should the provider/patient have questions regarding the notice.

f. Reasons for Deferral

- i. When an application for Free Care is deferred, the Person 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. This determination will not be required if the services were provided by facilities or practices participating in the NHSC Loan Repayment Programs.

- g. When an application is deferred, 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 the paragraph above and shall include the last sentence of that form.

5. Billing

- a. If a Person has been determined qualified for 100% Free Care under section 4, the Person shall not be billed for the services provided.
- b. If a Person has been determined qualified for 100% Free Care under section 4, the Person 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. MaineHealth 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 toll-free at (866) 804- 2499.

- d. If an individual's application for Free Care has been deferred under section 4, 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 section 4 or if the determination covering Free Care has been deferred under subsection 4.c., then no municipality shall be billed under the general assistance program for hospital care provided to that individual.

6. 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 Persons 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 Persons to whom each type of Free Care (required and not required) was provided.

7. Filing; Applicability

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

8. Notice of Opportunity for a Fair Hearing

- a. In accordance with 22 M.R.S.A. §1716, Maine Residents can contact DHHS 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, to request the opportunity for a fair hearing regarding eligibility for Free

Care. The Maine DHHS must grant the opportunity for a fair hearing regarding eligibility for Free Care to:

- Any applicant who requests it because his or her claim for Free Care is denied or not acted upon with reasonable promptness, or
 - Any recipient of care who requests it because he or she believes the hospital has taken an action erroneously.
 - Patients can contact Patient Financial Services toll-free at 1-866-804-2499 for additional information on requesting a hearing.
- b. New Hampshire residents can request a review of their determination for Free Care by contacting Patient Financial Services toll-free at 1-866-804-2499. The application will be reviewed for determination by Senior Revenue Cycle leadership.

9. Medical Indigence and Presumptive Eligibility

- a. MaineHealth 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. If you are approved for financial assistance under this 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. MaineHealth 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 toll-free at (866) 804-2499.

- i. Medical Indigence: There are three basic categories of Medically Indigent Persons considered in this Policy.

1. The first category includes those who qualify for Free Care based on their income, but who do not otherwise meet the Policy requirements. 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

2. The second category includes those patients who don't 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.
 3. Both categories of Persons above may 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.
 4. A third category of medically indigent patients may include out of state Cancer patients, who may be approved for Free Care on a case-by-case basis under this Policy. Out of state cancer 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.
- ii. 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 utilizing the FPL score provided by a revenue cycle partner, 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.
 - If a Person is covered by State of Maine MaineCare program or New Hampshire Medicaid, presumptive eligibility will be applied for services not covered prior to Medicaid enrollment, limited to service dates within the last year prior to enrollment with the State program.
 - If a Person is covered by CarePartners program, presumptive eligibility will be applied for services not covered prior to CarePartners enrollment, limited to service dates within the last year prior to enrollment with the State program.
 - Patient is incarcerated and has no assets.

- Prior qualifications for Free Care are not used to determine if someone is eligible for presumptive eligibility.
 - All services provided at the Preble Street Collaborative will be considered for presumptive eligibility under this program.
 - Patients referred for services to Mid Coast hospital from the Oasis Free Clinic in Brunswick will be considered for presumptive eligibility under this program.
 - Uninsured patients receiving mental health crisis care services at any MaineHealth emergency department will be considered for presumptive eligibility under this program.
1. Presumptive Eligibility patients will be approved for adjustment per internal Patient Financial Services Presumptive Eligibility Procedure or by leadership staff in the Patient Financial Services Department.

10. Assistance for State & Federal Programs

- a. 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 newborn 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 assessed for eligibility for 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 Person's Free Care application. This determination will not be required if the services were provided by facilities or practices participating in the NHSC Loan Repayment Programs.

11. Marketplace Plans

- a. 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 may contact our CarePartners team at 877-626-1684 for assistance.
- b. Patients who apply for Free Care who have been an inpatient at a MH Hospital will be assessed for eligibility for MaineCare (Medicaid) or New Hampshire Medicaid for Memorial Hospital patients. If the Person can supply a copy of the Health

Insurance Marketplace Eligibility Notification showing they would not be eligible for Medicaid, the MH staff will process the Person's Free Care application.

12. Contact Information for Financial Assistance

- a. An individual can apply for Free Care by contacting the Patient Financial Services office toll-free at (866) 804-2499. The Free Care application and this Policy can also be found on our website under the billing section.
- b. For alternative financial resources, patients may contact CarePartners. 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.

13. Physician Services Covered Under Financial Assistance

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

14. MH Billing and Collection Policy

- a. 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 120 plus days 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 Patient Financial services toll free at (866) 804-2499.

Related References:

Maine Department of Health and Human Services, Office of MaineCare Services. (2007). Chapter 150 [Word document]. Retrieved from <https://www.maine.gov/sos/cec/rules/10/144/144c150.doc>

Maine Revised Statutes, Title 22, Section 1716. (1995). Retrieved from <https://www.mainelegislature.org/legis/statutes/22/title22sec1716.html>

Original Adoption Date: 01/01/2012

Approval Committee(s):

This policy has been approved by representatives of MaineHealth member organizations in attendance at the {name of council or committee} meeting on {mm/dd/yyyy}.

Policy Owner: *Tony Murray, Sr. Director, Single Billing Office & Cash Operations, Revenue Cycle Management, MaineHealth Corporate*

Executive Sponsor: ~~*Rich Bayman*~~ ~~*Paul Chausse*~~ ~~*CFO, Vice President, Revenue Cycle Management,*~~
MaineHealth Corporate

Approved by the Maine Health Board of Trustees

Richard [Signature]

8/11/25

Attachment 1

NOTICE

Free Medical Care for Those Unable to Pay — 2025

Maine law requires that free medical care must be provided to Maine residents with income less than 150 percent of the federal poverty level. MaineHealth provides full free care to all patients **at or below 200 percent** 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.

Family Size	150%	200%
1	\$23,475.00	\$31,300.00
2	\$31,725.00	\$42,300.00
3	\$39,975.00	\$53,300.00
4	\$48,225.00	\$64,300.00
5	\$56,475.00	\$75,300.00
6	\$64,725.00	\$86,300.00
7	\$72,975.00	\$97,300.00
8	\$81,225.00	\$108,300.00
Each Additional	\$8,250.00	\$11,000.00

To apply for financial assistance, please contact us at:

- Patient Financial Services office toll free at **866-804-2499** during normal business Monday through Friday 8 a.m.-4:30 p.m.

Charges Will Not Exceed Amount Generally Billed to Medicare

If you are approved for financial assistance under our policy and your approval does not cover 100 percent 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.

