Central Maine Healthcare

Policy/Procedure: Financial Assistance Policy (FAP)	
ENTITY: **Central Maine Healthcare (CMH)** **CMH includes Central Maine Medical Center (CMMC), Bridgton Hospital (BH), Rumford Hospital (RH), Central Maine Medical Group (CMMG), the Maine College of Health Professions, long-term care facilities, clinics, and several other subsidiaries.**	**BOOK:** Administrative
	CHAPTER: Finance
	ORIGINATION DATE: 11/29/2019
	FINAL APPROVAL DATE: 7/30/2026

PERFORMED BY

This Policy applies to Central Maine Medical Center, Bridgton Hospital and Rumford Hospital facilities, practices, entities, services and its team members.

PURPOSE

Central Maine Healthcare (CMH) entities listed above, including all associated provider practices, provide financial assistance for emergency and medically necessary healthcare services received as an inpatient or outpatient to patients who are uninsured, underinsured, or otherwise unable to pay for care. Financial assistance is administered in a fair, consistent, respectful, and objective manner and is essential to fulfilling CMH's mission, vision, and values. This Policy is intended to remove financial barriers to medically necessary care while supporting CMH's commitment to provide access to safe, reliable, high-quality care for every patient, every day. The Policy establishes standardized procedures for identifying potentially eligible patients, processing applications, determining eligibility, and communicating financial assistance options. This Policy is designed to ensure compliance with applicable federal and state laws, including Internal Revenue Code Section 501(r) and Maine law, including 22 M.R.S. §1716-A, effective July 1, 2026. Requirements related to charity care eligibility, application processing timelines, patient notifications, billing protections, and payment plan limitations are incorporated throughout this Policy.

All official Central Maine Healthcare policies are maintained electronically and are subject to change. No printed policy should be taken as the official policy except to the extent it is consistent with the current policy that is electronically maintained.

PROCEDURE/PROCESS

I. IDENTIFICATION OF POTENTIALLY ELIGIBLE PATIENTS

A. When possible, prior to the service date of the patient, CMH will conduct a pre-admission interview with the patient, the guarantor, and/or his/her legal representative. If a pre-admission interview is not possible, this interview should be conducted at time of service or as soon as possible thereafter for higher dollar cases.

B. In the case of an emergency admission, the CMH evaluation of payment alternatives should not take place until the required medical care has been provided. At the time of the initial patient interview, the following information should be gathered but must not delay examination and treatment:

- Routine and comprehensive demographic data; and
- Complete information regarding all existing third-party coverage

C. All patients will be offered the opportunity to apply for financial assistance. When a patient requests financial assistance after leaving the facility, a Financial Advocate will mail a Financial Assistance Application to the patient/guardian for completion

D. Identification of potentially eligible patients can take place at any time during the Application Period

E. Financial advocates are generally available during regular business hours to provide the following services:

- Identify possible payment sources such as accident liability insurance or COBRA
- Screen patients for possible coverage under state, federal, or local assistance programs, including hospital financial assistance.
- Assist patients in applying for federal or state sponsored health insurance and financial assistance programs
- Discuss any financial questions
- Establish payment arrangements
- Provide price estimates
- Provide patients with an itemized bill upon request

F. CMH may rely on information obtained from other sources to determine whether the individual is eligible for assistance

II. MEASURES TO WIDELY PUBLICIZE THE FINANCIAL ASSISTANCE POLICY IN THE COMMUNITY

CMH and its member organizations will comply with all applicable laws, rules and regulations regarding notification to patients regarding financial assistance, including the following:

A. Posted signs and individual notices containing information on the availability of financial assistance are located in key public areas of the hospital, including but not limited to the following: Central Registration/Patient Access, Emergency Room waiting area, Clinic locations, hospital-employed physician practice waiting rooms, financial counselor locations and the Business Office

B. Paper copies of this Policy, the Financial Assistance Application, and the plain language summary will be available at the locations listed in Section A above, and will be offered to patients as part of the intake or discharge process

C. Information, such as brochures, will be included in patient services/information folders and/or at patient intake areas and upon request via phone, internet or in person.

D. A conspicuous notice regarding the availability of financial assistance, including the telephone number of the hospital office or department that can provide information about this Policy and the Financial Assistance Application process, and the URL or web address where copies of this Policy, the Financial Assistance Application, and plain language summary can be found, will be included on all billing statements

E. All public information and/or forms regarding the provision of financial assistance, including, but not limited to, this Policy, the Financial Assistance Application, and the plain language summary of the Policy, will use languages that are appropriate for the facility's service area in compliance with Section 1557 of the Patient Protection and Affordable Care Act. CMH will provide versions of the charity care application and the summary translated into any language spoken by 5% of the population of the State or 1,000 people in the State, whichever is less, as well as any additional languages spoken by 5% of the community served by the hospital or 1,000 people in the community served by the hospital, whichever is less.

F. The Financial Assistance Application, instructions, and plain language summary may be accessed via https://www.cmhc.org/patients-visitors/billing-financial-information/financial-assistance/

G. CMH will make a reasonable effort to orally notify an individual about the hospital's Financial Assistance Policy and about how to obtain assistance with the Financial Assistance Application process at least 30 days prior to the initiation of ECAs against the individual

H. If at any time during the Application Period the patient expresses an inability to pay, the patient will be informed of the availability of financial assistance and will be provided a Financial Assistance Application. The Financial Assistance Application and instructions may be accessed via https://www.cmhc.org/patients-visitors/billing-financial-information/financial-assistance/

III. METHOD FOR APPLYING FOR FINANCIAL ASSISTANCE

The patient should receive and complete a written Financial Assistance Application and provide all supporting data/documents required to verify eligibility. The types of data/documents that are required in support of the Financial Assistance Application are listed in the Financial Assistance Application instructions.

A. General Application Requirements

CMH shall make reasonable efforts to identify patients who may be eligible for financial assistance and shall assist patients in completing the application process upon request. Patients may apply for financial assistance at any time during the applicable application period.

CMH shall request only documentation reasonably necessary to determine eligibility under this Policy. CMH shall not require notarization of application materials or supporting documentation.

B. Application Processing Timelines

CMH follows all applicable timelines for review and determination as required by Maine law, including 22 M.R.S. §1716-A, effective July 1, 2026.

C. Presumptive Eligibility: A determination where a patient is presumed eligible for financial assistance based on financial and historical qualifiers. Final determination will be made upon completion and review of the financial assistance application. Criteria:

- Individual is eligible for certain state programs, i.e., SNAP, TANF;
- Individual is currently eligible for Medicaid, but was not at the date of service;
- Individual is homeless;
- Individual is deceased and has no known estate able to pay hospital debts;
- Individual is eligible by the State to receive assistance under the Violent Crimes Victims Compensation Act or the Sexual Assault Victims Compensation Act.

D. The Financial Assistance Application will serve as the record reflecting approval or denial of financial assistance

E. An approved Financial Assistance Application from any CMH entity will be utilized to presumptively determine eligibility for a period of six months from the approval date except if any of the following apply:

- Subsequent rendering of inpatient services;
- Income change;

- Family size change;
- Change in employment status

F. Individuals may contact any CMH Hospital for more information about the Financial Assistance Application process and for assistance with the Financial Assistance Application. Patients seeking Emergency Medical Care: CMH Hospitals will provide, without discrimination, care for emergency medical conditions (within the meaning of section 1867 of the Social Security Act (42 U.S.C 1395dd)) to individuals regardless of their eligibility for assistance under this Policy and as required under the Emergency Medical Treatment and Active Labor Act ("EMTALA"). CMH Hospitals will not engage in activities that discourage individuals from seeking emergency medical care, such as by demanding patients pay before receiving treatment for emergency medical conditions or by permitting debt collection activities that interfere with the provision, without discrimination, of emergency medical care

IV. EXTRAORDINARY COLLECTION ACTIONS (ECAs)

A. General requirements prior to initiating ECAs: CMH hospitals may not initiate any ECA for at least 120 days from the date the CMH hospital provides the first post-discharge billing statement for the care and until the individual has been notified of the FAP. Additionally, before engaging in ECAs against an individual, CMH hospitals must make reasonable efforts to determine whether an individual is eligible for financial assistance under the FAP in accordance with Section 1 below. ECAs may not be engaged in if the patient has made a satisfactory payment arrangement with the hospital. Finally, prior to commencing any ECA, the CFO or their designee must determine that the hospital has made reasonable efforts to determine whether an individual is FAP-eligible and has otherwise complied with this Policy. No ECA may be commenced prior to such determination by the CFO or their designee

B. Reasonable efforts: A CMH hospital will be deemed to have made reasonable efforts to determine whether an individual is eligible for financial assistance under the FAP if the CMH hospital either: (i) determines the individual meets the requirements for a presumptive eligibility determination; or (ii) provides adequate notice to the individual about the FAP and processes any FAP application submitted by the individual (whether the application is complete or incomplete)

- To make a presumptive eligibility determination, the hospital must determine that the individual is eligible for financial assistance based on information other than that provided by the individual or based on a prior FAP-eligibility determination
- In order to provide adequate notice to an individual about the FAP, CMH hospitals must notify the individual about the FAP at least 30 days prior to initiating one or more ECAs by providing the individual with a written notice that indicates financial assistance is available for eligible individuals, identifies the ECAs that the CMH hospital intends to use to obtain payment, and states a deadline after which ECAs may be initiated, which deadline is no earlier than 30 days after the date the written notice is provided

- Enclose a plain language summary of the FAP with the written notice
- Make a reasonable effort to orally notify the individual about the FAP and how the individual may obtain assistance with the FAP process

C. Additional procedures if an incomplete FAP application is submitted: In addition to complying with the notice requirements described in Section A above, CMH hospitals must provide individuals who submit an incomplete FAP application during the Application Period with notice about how to complete the FAP application and a reasonable opportunity to do so. In order to satisfy these requirements, CMH hospitals must do all of the following:

- Not initiate, or take further action on previously initiated ECAs
- Provide the individual with a written notice that contains the following information: description of the information and/or documentation under the FAP or FAP application form that must be submitted to complete the FAP application
- Contact information, including telephone number and physical location, of: (i) the hospital office or department that can provide information about the FAP; and (ii) either (a) the hospital office or department that can provide assistance with the FAP application process, or (b) at least one nonprofit organization or Government agency that CMH has identified as an available source of assistance with FAP applications

D. Additional procedures if a complete FAP application is submitted: In addition to complying with the notice requirements described in Section A above, CMH hospitals must do all of the following with respect to an individual who submits a complete FAP application during the Application Period:

- Not initiate, or take further action on previously initiated ECAs
- Make determination as to whether the individual is eligible for financial assistance under the FAP
- Notify the individual of the eligibility determination in writing, including the assistance for which the individual is eligible and the basis for the eligibility determination
- If the individual is determined to be eligible for financial assistance under the FAP, the CMH hospital must take all reasonable measures to reverse any ECA taken against the individual to obtain payment for the care (e.g. vacate any judgment, discharge any lien or levy, and remove any adverse information from a credit report)

E. Referral of debt to collection agencies: in addition to complying with the general requirements for ECAs set forth in Section A above, CMH hospitals must comply with the following additional requirements when referring an account to a debt collections agency:

- CMH hospitals require debt collection agencies to provide written assurances that the agency is compliant with the Fair Debt Collection Practices Act and the American Collections Association (ACA), Codes of Ethics and Professional Responsibility

F. Reporting to credit reporting agencies: in addition to complying with the general requirements for ECAs set forth in Section A above, CMH hospitals must comply with the following additional requirements when making a report to any credit reporting agency (e.g. Transunion, Experian, and Equifax):

- Accounts referred to a collection agency may be listed with a national credit reporting agency if the responsible party fails to make payment in full or a satisfactory payment arrangement with the collection agency

V. BILLING AND PATIENT PROTECTIONS

A. Notice of Non-Covered Services

CMH shall inform a patient who has been determined eligible for financial assistance if any portion of a medical service, treatment, procedure, test, or other hospital-provided service is not covered under the Financial Assistance Program. Such notice shall be provided prior to the delivery of the service whenever reasonably possible and shall clearly describe the service that is not covered and the patient's potential financial responsibility.

B. Limitation on Billing for Undisclosed Non-Covered Services

If CMH fails to provide advance notice that a medical service, treatment, procedure, test, or other hospital-provided service is not covered under the Financial Assistance Program, CMH shall not bill the patient for that service. Nothing in this section shall prohibit CMH from billing a patient's health insurance carrier for such services when otherwise permitted by law.

VI. LIST OF PROVIDERS DELIVERING EMERGENCY OR OTHER MEDICALLY NECESSARY CARE

A weblink to the CMH Financial Assistance Provider List is found at:

https://www.cmhc.org/patients-visitors/billing-financial-information/financial-assistance/

This page has a list of the providers at CMH hospitals who provide Emergency Care and/or Medically Necessary Care who are NOT covered by this Policy. CMH regularly updates its non-employed provider list in an effort to ensure the list remains accurate and up-to-date. However, there may be times when this list has not been updated to include a new provider or to reflect a change in a provider's status as covered or not covered by this Policy. CMH recommends that individuals consult with a CMH financial counselor whenever possible to confirm whether information about a particular provider is accurately reflected.

VII. MONITORING AND REPORTING

A. Financial assistance application log from which periodic reports may be generated shall be maintained aside from any other required financial statements

B. Financial assistance activity will be reported to the community annually, based on estimated costs of the services

SPECIAL CONSIDERATIONS:

I. LIMITATIONS:

A. This policy applies to:

- 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
- Non-Maine residents seeking emergency care and who meet the requirements outlined below

B. Financial assistance does not:

- Provide health insurance
- Act as a substitute or supplement for health insurance
- Guarantee benefits
- Cover non-CMH medical care providers
- Preclude minimum co-payments required by regulation or for clinical reasons (e.g. batterer's intervention program; narcotics treatment program)
- Cover Elective Cosmetic Surgery or services not meeting medical necessity

II. ELIGIBILITY FOR FINANCIAL ASSISTANCE:

A. Financial assistance for Medically Necessary Care is available to Maine Residents who:

- Have no health insurance coverage or have coverage that pays only part of the bill; and
- Meet the income criteria set forth below

B. Financial assistance for Emergency Care is available to Maine Residents and non-Maine Residents who:

- Have no health insurance coverage or have coverage that pays only part of the bill; and
- Meet the income criteria set forth below

C. CMH Hospitals provide 100% financial assistance (free care) based on criteria as defined below:

- Gross income is below or equal to 200% of the FPL
- Patient is a Maine resident receiving Emergent or Medically Necessary services and supplies
- Patient is not a Maine resident receiving Emergency Care
- All Third-Party Payer sources, including spend down, when appropriate have been exhausted

D. CMH Hospitals provide partial free care (the amount of partial free care will be equal to 100% of eligible charges, minus the AGB, but in no case will be less than 55%)

- Gross income is greater than 200% and less than or equal to 250% of the FPL
- Patient is a Maine resident receiving Emergent or Medically Necessary services and supplies
- Patient is not a Maine resident receiving Emergency Care
- All Third-Party Payer sources, including spend down, when appropriate have been exhausted

E. CMH Hospitals provide payment plans that are no greater than 4% of Modified Adjusted Gross Income (MAGI) for applicants with MAGI less than 400% of the Federal Poverty Level.

F. No individual eligible for financial assistance will be charged more for emergency or otherwise Medically Necessary Care than the calculated AGB

For questions about the Financial Assistance at Central Maine Healthcare, please contact

(207) 786-1803 or through the web at

https://www.cmhc.org/patients-visitors/billing-financial-information/.

DEFINITIONS

Amount Generally Billed (AGB): The amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care. To the extent applicable, AGB will be determined under the "look-back method" by taking the total payments the hospital received from all commercial plans and Medicare during the hospital's prior fiscal year and dividing this number by the total hospital charges to these commercial plans and Medicare during this prior year.
Patients who qualify for assistance will receive a discount either equal to or greater than the discount provided to insured individuals.

The AGB percentages listed below apply to any emergency or other medically necessary care provided to a FAP-eligible individual from the approval date of this policy.

Member Hospitals	Central Maine Medical Center	Rumford Hospital	Bridgton Hospital
AGB %	45.0%	51.2%	50.3%
Discount % Required	55.0%	48.8%	49.7%
Discount % Offered *	55.0%	55.0%	55.0%
True Self Pay	Medicare Rate	Medicare Rate	Medicare Rate

Application Period: The Application Period for Financial Assistance for a date of service expires 240 days from the first post discharge billing statement. The coverage for this application period for Financial Assistance is effective for 180 days following the date of determination for outpatient services. Inpatient services following initial determination date require an updated application.

Extraordinary Collection Actions (ECAs): Actions taken by a non-profit hospital against an individual to obtain payment for health care items or services provided by the hospital. A hospital must make reasonable efforts to determine whether an individual is eligible for financial assistance before engaging in these actions (26 U.S.C. § 501(r)(6)).

ECAs **do not include** placing hospital liens on a patient's property to obtain the proceeds of settlements, judgments, or compromises arising from a patient's suit against a third party who caused the patient's injuries.

ECAs also **do not include** a hospital's sale of an individual's debt to another party if, prior to the sale, the hospital enters into a legally binding written agreement with the purchaser of the debt containing four conditions:

- The purchaser of the debt must agree not to engage in any ECAs to obtain payment of the debt;
- The purchaser of the debt must agree not to charge interest on the debt in excess of the rate in effect under Section 6621(a)(2) of the Internal Revenue Code at the time the debt is sold (or such other interest rate set by notice or other guidance published in the Internal Revenue Bulletin);
- The debt must be returnable or recallable by the hospital upon a determination by the hospital or the purchaser that the individual is FAP-eligible; and
- If the individual is determined to be FAP-eligible and the debt is not returned to or recalled by the hospital, the purchaser must adhere to procedures specified in the agreement that ensure the individual does not pay, and has no obligation to pay, the purchaser and the hospital together more than the individual is personally responsible for paying as a FAP- eligible individual. ECAs also do not include the filing of a claim in a bankruptcy proceeding

Elective Cosmetic Surgery: CMS Medicare Hospital Manual, Section 250.11. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury or for improvement of functioning of malformed body member.

Emergency Care:

- An individual present at the Emergency Department ("ED") and a request is made for examination or treatment for any medical condition; or
- The patient is treated at a department or practice that is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment (e.g., an urgent care center, off-campus Labor and Delivery suite, etc.)

Family: "Family income" means cumulative income of a patient and the patient's family. "Family income" does not include the income of any individual residing in a patient's household who is not a member of the patient's family. For the purposes of this paragraph, "family" means a group of 2 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 on family.

Family Income

Includes:

- Gross 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, worker's compensation, strike benefits from union funds, veterans' benefits
- Public assistance including Temporary Assistance to Needy Families, and General Assistance money payments
- Training stipends
- 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

Does not Include:

- 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 focusing assistance

FAP-Eligible Individual: An individual eligible for financial assistance under the FAP (without regard to whether the individual has applied for assistance under the FAP).
Federal Poverty Level (FPL): The Federal Poverty Income guideline as determined by the United States Department of Health and Human Services and published in the Federal Register.

Financial Assistance Application: Application completed in accordance with the process set forth in Section III of this Policy.

Gross Charges: A hospital's full, established price for medical care that the hospital consistently and uniformly charges patients before applying any contractual allowances, discounts, or deductions.

Medically Necessary Care: Medical services or supplies which:

- Are ordered by a physician and appropriate and necessary for the symptoms, diagnosis, or treatment of the medical or mental health condition, including certain preventative services
- Are provided for the diagnosis or direct care and treatment of the medical or mental health condition;
- Meet the standards of good medical practice within the medical and mental health community in the service area;
- Are not primarily for the convenience of the patient or a provider; and
- The most appropriate level or supply of service which can safely be provided or, when necessary, as determined by utilization process review

Multiple Family Household: 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.

Resident:
State resident" means a person:

(1) Living in the State with the intent to remain in the State indefinitely.

(2) Who enters the State with a permanent, temporary, seasonal or other job commitment or who is seeking employment.

"*State resident" does not include a person who is in the State temporarily as a tourist or visitor.*

DISCLAIMER STATEMENTS

Extenuating circumstances may necessitate deviation from the terms of a Policy. It is understood that emergent situations may occur, which require immediate resolution. Where applicable, appropriate documentation should be created to support the necessity for such deviations.

CROSS REFERENCES

Central Maine Healthcare Billing and Collections Policy

REFERENCES AND SOURCES OF EVIDENCE

Requirements for 501(c)(3) Hospitals Under the Affordable Care Act – Section 501(r). (n.d.). Retrieved December 16, 2019, from https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r.

Maine Revised Statutes, Title 24-A, *Maine Insurance Code*, as amended. Policies and procedures shall be administered in compliance with all applicable provisions of Maine Revised Statutes Title 24-A and related state regulations.

REVIEW/APPROVAL SUMMARY
SUPERSEDES: N/A
REVIEW/REVISION DATES 11/20/2020, (02/04/2022), 08/23/2023, 10/22/2025, 7/30/2026
APPROVALS: Finance Committee

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