Financial assistance policy

New England Rehabilitation Hospital of Portland,
a Joint Venture of Maine Medical Center and Encompass Health
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Purpose

This policy outlines the circumstances under which the hospital will provide free medically necessary care to eligible patients who are unable to pay for their care, as determined by the hospital in accordance with the eligibility criteria and other terms specified in this policy. Patients are expected to cooperate with the hospital's procedures for obtaining Financial Assistance, securing insurance or other forms of payment, and contributing to the cost of their care based on their ability to pay.

This policy applies to emergency or medically necessary care provided by the hospital. This policy does not apply to care that is not emergency or medically necessary care, including elective services or items that are solely for the comfort or convenience of a patient. This policy does not apply to care delivered by physicians or other healthcare providers who bill "privately" (separate from the hospital). (See Attachment A for additional information about physicians and other healthcare providers providing care within the hospital.)

Financial Assistance does not apply to amounts that are covered by insurance, governmental programs or other funding sources (which may include, but are not limited to, workers' compensation, automobile or other liability insurance, crime victims' compensation funds, and litigation recoveries). To be eligible for Financial Assistance, a patient is expected to apply for and comply with all processes related to seeking assistance from other insurers and/or third-party sources of payment (including all applicable governmental programs) as requested by hospital staff. Patients who are noncompliant or uncooperative in attempting to obtain insurance coverage, qualification under governmental programs, or payment from third-party sources will not be eligible for Financial Assistance.

A patient will be ineligible for Financial Assistance if the patient, or his or her representative, provides false information or falsified documentation of household size, income or other pertinent information.

Definitions

Covered Services – emergency or medically necessary care provided by the hospital. Covered Services do not include services that are not emergency or medically necessary care, or care that is provided by physicians or other healthcare providers who bill "privately."

Emergency or medically necessary care – services that are necessary and appropriate to sustain life or to prevent serious deterioration in the health of the patient from injury or disease. Medically necessary, for purposes of an inpatient stay, is defined as a CMS-13 qualifying condition.

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 related individual, the income guidelines are applied separately to each family and/or unrelated individual, and not to the household as a whole.)

Financial Assistance – reduction of an eligible patient's account balance for Covered Services under the terms of this policy.

Patient – the individual receiving medical treatment and/or, in the case of an unemancipated minor or other dependent, the parent, legal guardian or other person (guarantor) who is financially responsible for the patient.

Uninsured – a patient who does not have health insurance coverage, is unable to obtain affordable coverage, and is ineligible for government healthcare programs or other third-party payment sources.

Underinsured – a patient who is not uninsured, but whose out-of-pocket medical expenses exceed his or her financial ability to pay.

Policy

Subject to the terms of this policy, Financial Assistance is provided to eligible patients who are uninsured or underinsured.

Eligibility for Financial Assistance is based on an individualized assessment by the hospital of a patient's financial need, generally determined by measuring the patient's gross family income against the Federal Poverty Guidelines as specified in the Financial Assistance Discount Guidelines in Attachment B, provided that the patient does not have other funding sources that could be used to pay for his or her care. The Financial Assistance Discount Guidelines are adjusted annually to reflect changes in the Federal Poverty Guidelines. If annual income is equal to or less than 150% of the federal poverty level, the applicant will receive 100% free care. If the annual income exceeds 150% of the federal poverty level, the applicant is responsible for 100% of unpaid medical services.

A patient determined to be eligible for Financial Assistance will not be billed more than the amount generally billed for emergency or other medically necessary care by hospital to individuals who have insurance covering such care. (See Attachment B for additional information about the "amount generally billed" limitation.)

If a patient is underinsured and is determined to be eligible for Financial Assistance, discounts will only apply to the balance due from the patient after insurance payments and other third-party payment sources have been applied to the account.

For purposes of this policy, "income" includes, but is not limited to, revenue from the following sources (before taxes):

- 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; and
- net gambling or lottery winnings.

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; and
- 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 Financial Assistance to bills not covered by such payments.

To apply for Financial Assistance, a complete Financial Assistance Application is required. A complete Financial Assistance Application is inclusive of, but not limited to, disclosure of household size, employment information, income and other financial resources and supporting documents (such as recent tax returns and pay stubs), as detailed in the Financial Assistance Application. If documentation proving household income is not available, patients may call the hospital finance department at the phone number listed above to discuss other evidence demonstrating eligibility. Failure to provide the required information and documentation in a timely manner may result in ineligibility for Financial Assistance.

Complete Financial Assistance Applications should be submitted to the hospital at the address listed above. A hospital finance representative will review the application for completeness. Financial Assistance determinations must be approved by the Facility Controller, and in certain circumstances, by the hospital CEO. The hospital will notify patients in writing of the decision on their eligibility under this policy. If a patient has been determined qualified for Financial Assistance under this policy, the patient shall not be billed.

Hospital will allow the determination of qualification for outpatient Financial Assistance to remain valid for up to six months. A determination of qualification for inpatient Financial Assistance shall be made with each admission.

All patients will be offered a plain language summary of the Financial Assistance Policy during discharge or intake.

Billing statements will contain a written conspicuous notice informing patients about the availability of financial assistance, a telephone number where they may receive more information, as well as website address where the Financial Assistance Policy, application and plain language summary may be found.

Once a patient has been discharged and the patient's balance due has been determined, the Billing Office will mail the patient monthly account statements and make phone calls in an attempt to collect the outstanding balance. If no payment has been received for 120 days, the account may be sent to a third-party collection agency.

The hospital, and any third parties acting on its behalf, do not engage in extraordinary collection actions such as lawsuits, liens, foreclosures, wage garnishment or reporting adverse information to credit agencies. For additional information, please see the Billing and Collections Policy, which may be downloaded from hospital website. Copies are also available upon request, free of charge, by mail and in admitting/registration areas of the Hospital.

Copies of this policy, a plain language summary of this policy and the Financial Assistance Application are available free of charge upon request by writing to the address above. These documents can be found in the admitting/registration areas of the hospital and may also be downloaded at hospital's website.

Further information about this Financial Assistance Policy and assistance with the application process are available by calling Hospital Phone Number, or in person during normal business hours or by appointment from a hospital finance representative.

Nondiscrimination & emergency medical care

Hospital does not have a dedicated emergency department. The hospital will appraise emergencies, provide initial treatment, and refer or transfer an individual to another hospital/facility, when appropriate, without discrimination and without regard to whether the individual is eligible for Financial Assistance.

Hospital will not engage in actions that discourage individuals from seeking emergency medical care, such as demanding that an individual pay before receiving initial treatment for emergency medical conditions or permitting debt collection activities that interfere with hospital's appraisal and provision, without discrimination, of such initial treatment.

Notice of opportunity for a fair hearing

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

- Any applicant who requests it because his or her claim for Financial Assistance 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.

Procedure to request an administrative hearing

An applicant for Financial Assistance may request an Administrative hearing if he or she is aggrieved by the action that denies the request for Financial Assistance. 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.

- An Administrative Hearing may be requested by an applicant or his/her representative.
- 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.
- 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.
- 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.
- 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.
- The Department, the hospital and the applicant may be represented by legal counsel and may have witnesses appear.
- 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.
- 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.
- 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.
- 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.

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.

- The claimant withdraws the request for a hearing.
- The claimant, without good cause, abandons the hearing by failing to appear.
- The sole issue being appealed is one of federal or state law requiring an automatic change adversely effecting some or all applicants for Financial Assistance.
- 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.

Corrective action

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

- The hearing decision is favorable to the applicant; or
- DHHS decides in the applicant's favor before the hearing.