UMass Memorial Medical Center

Financial Assistance and Credit and Collection Policy

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Date: 12/07/2017

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Developed By: James Graves, Sr. Director Patient Financial Services	**Effective Date:** 12/13/2017 **Approved by:** Therese Day, CFO
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Policy:

The Credit and Collection Policy sets forth the standards by which UMass Memorial Medical Center, Inc. will administer the collection of insurance/financial information from patients, the determination of eligibility for Financial Assistance, and the billing and collection processes, in accordance with (1) The Executive Office of Health and Human Services (EOHHS) regulations 101 CMR 613.00 Health Safety Net Eligible Services (2) the centers for Medicare and Medicaid services Medicare Bad Debt Requirements (42CFR 413.89), 13J the Medicare Providers Reimbursement Manual (Part 1, Chapter 3), and (3) The Internal Revenue Code Section 501 (R) as required under section 9007 (a) of the Federal Patient Protection and Affordable Care Act (Pub. L. No. 111-148) and as clarified in the December 29, 2015 IRS clarification to reporting such information in the hospital IRS 990 form. The Financial Assistance and Credit and Collection policy will be filed electronically with the Health Safety Net Office in accordance with the requirements of the regulation.

UMass Memorial Medical Center, Inc. does not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual orientation, gender identity, age or disability in any of its policies concerning the acquisition and verification of financial information, preadmission or pretreatment deposits, payment plans, deferred or rejected admissions, or Low Income Patient status.

I. <u>Delivery of Health Care Services:</u>

A. To assure that all patients presenting to UMass Memorial Medical Center (UMMMC) requesting examination or treatment for an emergency medical condition receive an appropriate medical screening examination, stabilization, and if necessary, transfer in accordance with the Emergency Medical Treatment and Labor Act (EMTALA).

UMMMC will not engage in activities that discourage individuals from seeking emergency medical care. This includes delay in the provision of an appropriate medical screening examination or further medical examination and treatment to stabilize the medical condition in order to inquire about the individual's method of payment, insurance status, or to secure signatures on a financial responsibility or advanced beneficiary notification form. UMMMC will not permit debt collecting activities in the emergency department or other areas of the hospital facility where such activities could interfere with the provision of emergency care. Request for

insurance co-payments will not be made prior to a medical screening examination and stabilization.

1. Emergency Level Services include:
   Medically necessary services provided after the onset of a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity including severe pain, for which the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of the person or another person in serious jeopardy, serious impairment to body function or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further defined in section 1867(e) (1) (B) of the Social Security Act, 42 U.S.C. § 1295dd(e)(1)(B). A medical screening examination and any subsequent treatment for an existing emergency medical condition or any other such service rendered to the extent required pursuant to the federal EMTALA (42 USC 1395(dd)) qualifies as an Emergency Level Service.

2. Urgent Care Services include:
   Medically necessary services provided after sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson would believe that the absence of medical attention within 24 hours could reasonably expect to result in placing the patient's health in jeopardy, impairment to bodily function, or dysfunction of any bodily organ or part. Urgent Care Services are provided for conditions that are not life threatening and do not pose a high risk of serious damage to an individual's health, but for which prompt medical services are needed.

   Note Regarding EMTALA:
   In accordance with federal requirements, EMTALA is triggered for anyone who comes to the hospital property requesting examination or treatment of an emergency level service (emergency medical condition), or who enters the emergency department requesting examination or treatment for a medical condition. Most commonly, unscheduled persons present themselves at the emergency department. However, unscheduled persons requesting services for an emergency medical condition while presenting at another inpatient unit, clinic, or other ancillary area may also be subject to an emergency medical screening examination in accordance with EMTALA. Examination and treatment for emergency medical conditions or any such other service rendered to the extent required under EMTALA, will be provided to the patient and will qualify as emergency care. The determination that there is an emergency medical condition is made by the examining physician or other qualified medical personnel of the hospital as documented in the medical record. The determination that there is an urgent or primary medical condition is also made by the examining physician or other qualified medical personnel of the hospital as documented in the medical record.

B. **Non-Emergent, Non-Urgent ("Elective") Medically Necessary Services** - For patients who either (1) arrive at the hospital seeking non-emergent or non-urgent level care or (2) seek additional care following stabilization of an emergency medical condition, UMMMC will collect financial information from the patient, assist the patient with obtaining/verifying coverage for services and/or make other financial arrangements described herein.

Elective Services: Medically necessary services that do not meet the definition of Emergency or Urgent above. Typically, these services are either primary care/specialty services or medical procedures scheduled in advance by the patient or by the health care provider.

C. **Serious Reportable Events** -UMMMC maintains compliance with applicable billing requirements, such as the Department of Public Health requirements for non-payment of certain Serious Reportable Events. UMMMC will not bill any patient, including Low Income Patients for claims related to Serious Reportable Events.

II. Collecting Financial Information from Patients

UMMMC will make reasonable efforts and attempt to obtain all relevant financial, demographic, insurance and third party liability information from patients prior to elective services being rendered as described below. This information will be collected from patients requiring emergent/urgent care as soon as possible but only when permitted in accordance with EMTALA.

A. **Patients with Insurance Coverage**- For patients with health insurance or for patients covered by a Workers Compensation, Automobile Insurer, or any other third party responsible for the payment of services provided, UMMMC will make best efforts to collect all information required to submit a claim to the insurance carrier for services rendered

1. **Insurance Verification**- Whenever possible, UMMMC will verify a patient's insurance eligibility via electronic or telephonic means, as well as the MassHealth Eligibility Verification (EVS) System for verification of eligibility in a public assistance program, prior to the patient's arrival for each date of service. When this does not occur, eligibility will be verified upon arrival, or as soon as possible thereafter, by electronic/telephonic means and/or review of the patient's insurance card.
2. **Referral and Authorization Requirements**- UMMMC will attempt to secure and/or verify all referrals and authorizations required by a patient's insurance carrier prior to services being rendered.
3. **Co-Payments/Co-Insurance/Deductibles/Non-Covered Services**- When an insured patient is responsible for a portion of the bill, UMMMC will attempt, when reasonable, to collect that amount, or establish payment arrangements prior to services being rendered. If unable to collect the amount due prior to service, UMMMC will pursue it via the billing and collection process.
4. **Required Forms**- All insured patients will be expected to sign an Assignment of Benefits (AOB) form and any other forms required by their insurance

carrier or by regulation in order to bill and collect from their third party insurer. If UMMMC is unable to obtain a signed EOB, the patient will be responsible for the total charges.

B. **Patients without Insurance Coverage**- UMMMC will attempt to assist all patients registered as "Self-Pay" with identifying and securing coverage, and/or establishing a payment plan for amounts determined to be a patient responsibility.

1. Signs will be posted in English, Spanish, Portuguese, Arabic and Vietnamese informing patients of the availability of Financial Assistance, and whom to contact for assistance in applying. These signs will be clearly visible posted in areas with high patient traffic including the following:
    a. Admitting Offices and Waiting Areas
    b. Outpatient Registration and Waiting Areas
    c. Emergency Registration and Waiting Areas
    d. Financial Counseling Offices located at UMMMC
    e. The Patient Financial Services Customer Service Office
2. Individual flyers notifying patients that Financial Assistance is available for qualified patients will be available at all Admitting, Registration and Financial Counseling locations.
3. All Ambulatory Clinic patients and patients scheduled for an elective procedure, registered as Self-Pay will be referred to a Certified Application Counselor. All inpatients registered as Self-Pay will be visited by a Certified Application Counselor during their admission, or contacted post discharge.
4. Initial patient bills and all subsequent statements will include a notice alerting patients to the availability of Financial Assistance and a phone number to call.

III. <u>Financial Assistance Programs of the Commonwealth of Massachusetts</u>

UMMMC offers extensive financial assistance to patients based on family income level and other criteria described below. UMMMC has contracted with the Executive Office of Health and Human Services (MassHealth) and the Commonwealth Health Insurance Connector Authority (Connector) and has been deemed a Certified Application Counselor Organization. UMMMC employs a large staff of Certified Application Counselors (CAC) that is available throughout UMMMC to assist individuals that are seeking help in applying for Financial Assistance.

In order to assist patients with the appropriate financial assistance coverage CAC's will:

- Provide information on all available programs.
- Provide patients with the appropriate application(s) for MassHealth, Health Safety Net, and Children's Medical Security Program, Premium Assistance Payment Programs operated by the Health Connector, Medical Hardship and other types of financial assistance that may cover all or some of their unpaid medical bills.
- Assist patients in the application and renewal process.
- Work with patients to obtain any required documentation.

- Make reasonable, diligent efforts to follow up on the application status through the final determination.
- Help patients enroll in a health insurance plan.
- Offer and provide voter registration assistance.

A. Health Safety Net-Massachusetts law provides coverage for healthcare services via the Health Safety Net for low income patients based on Massachusetts residency, verification of identity, and documented MassHealth Adjusted Gross Income (MAGI) or Medical Hardship Family Countable Income equal to or less than 300% of the Federal Poverty Income Guidelines (FPIG).
Individuals are not eligible for Health Safety Net if they have

- Been determined eligible for MassHealth or a Premium Assistance Program operated by the Health Connector, including the premium assistance program, and have failed to enroll or coverage has terminated due to non-payment of premiums.
- Access to employer sponsored health insurance coverage that is deemed affordable with the exception of the waiting period.

1. **Health Safety Net -Primary-**Uninsured patients with verified MassHealth MAGI household income or Medical Hardship Family Countable Income of 0-300% of the FPIG may be determined to be Low Income Patients based on EOHHS Guidelines and eligible for Health Safety Net Eligible Services, subject to the stipulations below.

    a. Low Income Patients eligible for enrollment in a Premium Assistance Payment Program operated by the Health Connector are eligible for a period of 100 days beginning on the patient's Medical Coverage Date.
    b. Students subject to the state's Student Health Program requirements are not eligible for Health Safety Net - Primary.

2. **Health Safety Net - Secondary**. Patients with other primary health insurance, including students enrolled in a Qualifying Student Health Plan and verified MassHealth MAGI Household income or Medical Hardship Family Income of 0-300 % of the Federal Poverty Income Guidelines (FPIG) may qualify as a Low Income Patient and be eligible for Health Safety Net – Secondary, subject to the following exceptions.

    a. Health Safety Net – Secondary will only cover dental services for individuals enrolled in and not covered by a Premium Assistance Program Operated by the Health Connector effective on the 101st day from the Medical Coverage Date.
    b. Health Safety Net – Secondary will only cover adult dental services provided by community health centers, hospital licensed health centers, or a satellite clinic for individuals enrolled in MassHealth Standard, CommonHealth, MassHealth CarePlus and Family Assistance, excluding MassHealth Family Assistance-Children.

3. **Health Safety Net –Partial**–A Low Income Patient eligible for either Health Safety Net Primary or Health Safety Net Secondary with verified MassHealth MAGI Household income or Medical Hardship Family Countable Income between 150 % and 300% of the FPIG may be eligible for Health Safety Net-Partial with an annual family deductible. The annual deductible will only apply if all members of the Premium Billing Family Group (PBFG)'s income is greater than 150 % of the FPL.
   If determined eligible, the annual deductible is equal to the greater of

   1. 40% of the difference between the lowest of either MassHealth MAGI Household income or the Medical Hardship Family Countable Income in the applicant's PBFG, and 200% of the FPL.
   2. The lowest cost Premium Assistance Program Operated by the Health Connector premium for the family size and income level at the start of the calendar year.

   If any member of the PBFG has an income that is below 200% of the FPIG there is no deductible for any member of the PBFG. Expenses over this deductible amount will be exempt from billing and collection activity.

   UMMMC Certified Application Counselors will track the allowed reimbursable expenses until the patient has met their deductible. If the patient has received services from more than one provider, it is the patient's responsibility to track the deductible amount and notify UMMMC when the deductible is met. Copayments and Pharmacy expenses will not be applied to the deductible.

   UMMMC Collection staff track deductible payments. If a patient/family defaults on their deductible responsibility, UMMMC will then follow the billing and collection procedures for Self-Pay accounts as described in the Self-Pay accounts section of this policy. The application process, State coverage exclusions and income verification procedures are the same as those for Health Safety Net - Primary.

4. **Health Safety Net- Presumptive Eligibility -** at times a patient may qualify for Health Safety Net and be unable to complete a full application on the date of service. UMMMC may determine the individual to be a Low Income Patient according to Health Safety Net income and household guidelines, for a limited period of time. The determination will be based on self-attested information provided by the patient on the form specified by the Health Safety Net Office. The eligibility period will begin on the date that UMMMC makes the determination and will continue until the last day of the following month or the individual submits a full application and receives a determination from Mass Health or the Health Connector.

B. Medical Hardship- A Massachusetts resident at any countable income level may apply for Medical Hardship if medical costs have so depleted the family's income

that he or she is unable to pay for eligible services. The applicant's Allowable Medical Expenses, as defined below, must exceed a specified percentage of the applicant's countable income as follows:

Income Level	Percentage of Gross Income
0 - 205% FPL	10%
205.1 - 305% FPL	15%
305.1 - 405%	20%
405.1 - 605% FPL	30%
>605.1% FPL	40%

The Health Safety Net Office will provide the application and process Medical Hardship determinations based on documentation submitted by UMMMC and the patient. UMMMC will submit the Medical Hardship application within 5 business days of receipt of all required documentation provided by the patient. The Health Safety Net Office will review and process an application for Medical Hardship if the applicant's Allowable Medical Expenses exceed the percentage of Countable Income listed above. The Health Safety Net Office will not process a Medical Hardship application for anyone with income less than 405% of the FPIG unless the individual first submits an application to the MassHealth Agency and receives a determination. Two Medical Hardship applications may be submitted in a 12 month period.

1. Allowable Medical Expenses- The total of Medical Hardship family medical bills from any health care provider that, if paid, would qualify as deductible medical expenses for federal income tax purposes. This may include paid and unpaid bills for which the patient is still responsible and incurred up to twelve months prior to the date of the application. This does not include bills incurred while an applicant is a Low Income Patient unless they are Dental-Only Low Income Patient on the date of service. If a patient has not received a bill for more than 9 months from the date of service, it may still be allowed if the Medical Hardship application is submitted within 90 days of the initial billing. Unpaid bills included in a Medical Hardship determination will not be included in a subsequent Medical Hardship application. This will not include bills for services that are incurred by patients while enrolled in MassHealth or a Premium Assistance Payment Program operated by the Health Connector.

2. Applicant Contribution- the specified percentage of countable income as listed above. There is one Medical Hardship contribution per each Medical Hardship determination.

3. Notification of Determination- the Health Safety Net Office will notify applicants of the determination. This will include the following:

    - The dates for which allowable Medical Expenses may be included.
    - The amount of the applicant's Medical Hardship contribution.
    - The services that do not qualify as eligible services.

- The name and number of a contact person for more information.
- The denial notice will explain the denial reason.

4. Provider Notification- The Health Safety Net will notify the provider of the following:

    - The determination with bills included in the applicant's Allowable Medical Expenses.
    - The applicant's contribution to each Health Safety Net Provider based on the gross charges and dates of service provided to the applicant's family.

5. UMMMC will submit claims for Medical Hardship Services that exceed the patient's Medical Hardship contribution.

6. UMMMC will bill the applicant for the Medical Hardship contribution unless they have a Low Income Patient status or eligible for MassHealth.

7. UMMMC will cease any collection efforts against an emergency bad debt claim that is approved for Medical Hardship under the Health Safety Net program.

8. UMMMC will cease collection efforts on bills that are listed on the Medical Hardship determination and would have been eligible for Medical Hardship payment if for any reason the application was not filed within 5 business days.

C. State Coverage Exclusions listed below are situations where coverage will not be provided by Health Safety Net. (Note: Some of these services are covered through UMMMC's "Additional Coverage and Discounted Care" described in Section VI).

1. Non-medically necessary services.
2. MassHealth, Connector Care, and private insurance co-pays.
3. Claims denied for any administrative or billing error.
4. Services provided to a patient with private health insurance that are considered out of the health insurance provider network.

D. Application Process –Patients seeking financial assistance will be required to apply for coverage for MassHealth, Premium Assistance Program Operated by the Health Connector, Health Safety Net and the Children's Medical Security Program. Patients must complete and submit, with the assistance of the CAC, an application via the Health Insurance Exchange located on the State's Health Connector website, a paper application provided by MassHealth, or an application by telephone with the customer service representative located at either MassHealth or the Connector. The MassHealth Agency or the Health Connector will process all applications and notify the individual of his or her eligibility determination for MassHealth or qualification

for a Premium Assistance Program Operated by the Health Connector or Low Income Patient (Health Safety Net) status.

In special circumstances, UMMMC may apply for the patient using a specific form designated by the Health Safety Net's Office for individuals seeking financial assistance coverage due to being incarcerated, victims of spousal abuse, deceased, confidential services to minors, presumptive Low Income Patient status or applying due to a medical hardship.

E. Income Verification- Household income may be verified either through electronic data matches, or paper verifications. MassHealth utilizes federal and state data sources to attempt to match income stated on the application. Income will be considered verified if through the state data match is reasonably compatible with the stated income. If MassHealth is unable to verify income through an electronic data match, it must be verified by one or more of the following:

1. **Earned Income:**
    - Recent pay stubs
    - A signed statement from the employer
    - The most recent Federal tax return
    - Other comparable source
2. **Unearned Income:**
    - A copy of a recent check or pay stub from the income source
    - A statement from the income source where matching is not available
    - The most recent Federal tax return
    - Other comparable source

F. Identity Verification- Applicants must provide proof of their identity with, but not limited to documents that contain a photograph or other identifying information, such as, name, age, sex, race, height, weight, eye color and address. Acceptable documents are:

- Driver's license issued by a state or territory
- Identification card issues by a school, military, a federal, state or local government, a military dependent card or U.S. Coast Guard Merchant Marine
- Clinic, doctor, hospital or school record for children under 19 years of age
- Two documents that provide information that is consistent with the applicant's identity such as, but not limited to, high school and college diploma, marriage or divorce records, property deeds, rental agreements
- A finding of identity from a federal or state agency, if the agency has verified the identity
- An affidavit signed, under penalty of perjury, by another person who can reasonably testify to a person's identity, if no other documentation is available

IV. UMass Memorial Health Care System Financial Assistance Program

It is the policy of UMass Memorial Health Care System to provide discounted care to qualified patients in accordance with IRS Section 501 (r). For those that have been determined eligible, UMass Memorial Health Care System will not charge more than the amount generally billed to a patient that has insurance coverage for urgent, emergency and medically necessary services. The Patient Financial Counseling department will be the point of contact to provide to patients the written policy, a summary of the policy, the application form and assistance with the application process.

A. Application Process

An applicant applying for Financial Assistance must submit a completed and signed UMass Memorial Health Care Financial Assistance Application. The application must be accompanied by all required income verifications.

One application will be sufficient for all family members listed on the application.

B. Eligibility

In order to be determined eligible for the UMass Memorial Health Care Financial Assistance Program an applicant must meet the following criteria:

- Income and family size must be between 0-600% of the federal poverty level guidelines.
- Complete and sign a financial assistance application.
- Provide income verification for all applicable household members.
- Apply for any state or government medical assistance for which they may be eligible.
- Initiate the application process 240 days from the date of the first bill/statement.

C. Complete Application

A Financial Assistance application will be considered a "complete application" when the following criteria have been met:

- The application has been received in the Patient Financial Counseling Department.
- The patient/guarantor or an authorized representative has signed the application.
- All questions on the application have been answered.
- Income verification that is sufficient to make an eligibility determination has been provided.

A complete application will be evaluated by a Financial Counselor to determine eligibility. All applications will be reviewed by a Patient Financial Counseling Supervisor for final approval.

1. If all eligibility criteria have been met, a letter of approval will be sent to the applicant/guarantor that will indicate the eligibility period and percentage of discount.

2. If all eligibility criteria have not been met, a letter of denial will be sent to the applicant/guarantor.

3. Applications that have been approved and processed will be maintained in a central file in the Central Business Office.

D. Incomplete Application

If the Financial Assistance application is not complete, a Financial Counselor will send one follow-up letter to the patient. This letter will indicate the information that is necessary to process the application.

The applicant/guarantor must provide the required documentation within 30 days of receipt of the follow-up letter. If the information is not received within this time frame, the application will be denied. A letter with the reason for denial will be sent to the applicant.

A 30-day grace period will be allowed from the date of the denial for the applicant/guarantor to provide additional information. At the end of the 30-day grace period a new application must be completed.

E. Income Verifications

The applicant/guarantor must provide verification of income.

Acceptable verifications of income are as follows:

- 2 most recent pay stubs.
- A copy of the most recent pension, social security, unemployment or other income benefits statement or check.
- For the self-employed the last 3 months profit and loss statement.
- A copy of the most recent tax returns as long as it is not over 6 months old.
- A statement from an employer indicating gross weekly income.
- For alimony/child support a copy of a court decree or a check of payments received.
- A signed statement of support for an applicant/family member that does not have any income.

F. Eligibility Period

The financial assistance eligibility will begin the date the signed completed application is received in the Patient Financial Counseling Department. Eligibility

will be in effect for one year from the date of approval. An application will be deemed complete when all eligibility criteria have been met.

The eligibility period will also cover a period of 12 months retroactive from the date of approval. The same eligibility period will pertain to all eligible household family members listed on the application.

Financial Assistance will be terminated if at any time the criteria for eligibility have changed to the extent that the applicant would no longer be eligible. This may consist of changes to income, the number of household family members, or eligibility of state or government medical assistance programs. In such cases, the applicant will be notified via a letter of any termination of assistance. The reason for termination will be indicated.

G. Eligible Services

Financial Assistance discounts that have been approved for the UMass Memorial Health Care Financial Assistance Program will only apply to urgent, emergency and medically necessary care. This will include but not be limited to inpatient, observation, outpatient services and land ambulance transportation. Only emergency or other medically necessary care provided within the Hospital Facility by the Hospital Facility itself is covered. It only applies to such care provided by employees of the Hospital Facility and other costs incurred directly by the Hospital Facility.

H. Non Eligible Services

Non-medically necessary services will not be eligible for the Financial Assistance discount. These services include, but are not limited to, cosmetic surgery, infertility services, hearing aids, and social and vocation services. Non-medically necessary services will be billed at full charges.

UMass Memorial Medical Center (the “Hospital Facility”) does not employ its own physicians. Each physician or other third party provider, if any, bills for their own services and follows their own financial assistance and billing and collection procedures. Accordingly, the services provided by the physicians or other third party providers, are not covered by UMass Memorial Medical Center’s Financial Assistance and Credit and Collection Policy.

Per the above statement, services rendered by physicians or other clinicians in the specialty areas identified below are not covered by the UMassMemorial Medical Center Financial Assistance and Credit and Collection Policy.

Allergy & Immunology	Internal Medicine
Ambulance (Air/Land)	Laboratory (Quest)
Anesthesiology	Nephrology
Audiology	Neurology
Behavioral Health	Obstetrics & Gynecology
Cardiology	Occupational Medicine
Cardiovascular Disease	Orthopedic
Critical Care Medicine	Pathology (Anatomic and Clinical)
Dentistry	Pediatrics
Dermatology Durably Medical Equipment	Physical Medicine & Rehabilitation
Durable Medical Equipment	Psychiatry
Ear, Nose, Throat	Pulmonary Medicine
Emergency Medicine	Radiology
Endocrinology	Renal Medicine
Primary/Family Medicine	Sport Medicine
Gastroenterology	Sport Medicine
Geriatrics, Palliative Care & Post Acute	Surgery
Hematology/Oncology	Telemedicine
Infectious Disease	Vision

I. Basis for Calculating Amount Charged

UMassMemorial will utilize the look back method to determine the percentage of the amount generally billed to patients as it applies to this Financial Assistance Policy. A combination of the previous year charges and payments for commercial and Medicare

insurance products are used to determine the effective net collection rate observed by the organization. Currently, the amount being charged to patients who are deemed eligible to benefit under the Financial Assistance Program is 25% of charges. Patients who qualify for the Financial Assistance Program and who have insurance coverage will have their financial obligations (such as copayments and deductibles) after payments by insurance capped at no more than 25% of total charges. All insurance claims, payments and adjustments will be made and taken before any financial assistance discount is applied.

J. Widely Publicize

The Patient Financial Counseling Department will be the point of contact for patients to request and obtain, free of charge, a paper copy of the policy, a plain language summary of the policy and the application. All three may be requested by telephone, in person or email as noted below:

UMass Memorial Patient Financial Counseling Contact Information:

- Telephone: 508-334-9300
- Internal email: Financial Counseling
- External email: needinsurance@umassmemorial.org
- Address: Patient Financial Counseling
  306 Belmont St.
  Worcester, MA 01604

The Credit and Collection and Financial Assistance policy, the plain language summary and the application may be accessed using the UMassMemorial Health Care web site: www.umassmemorialhealthcare.org, under the section Patients and Visitors, Financial Counseling.

V. Additional Coverage and Discounted Care Provided by UMMMC to Patients

A. Continuation of Coverage- Although not covered through the Health Safety Net Office, UMMMC will continue to extend Free Care coverage for medically necessary services to approved Low Income Massachusetts Patients for UMMMC Ambulance Services.

B. Prompt Payment Discount- UMMMC may grant a discount to patients of any income level who pay, or secure via credit card, their self-pay balance prior to, or immediately after services being rendered. The discount reflects the time value of money, the avoidance of billing and collection costs, and the avoidance of credit risk. The standard discount will be 20% of the net patient obligation. No higher discount may be offered unless based on unique circumstances and approved by the Sr. Director of Patient Financial Services.

VI. Billing and Collection Procedures

UMMMC must administer billing and collection processes that are efficient and effective in securing amounts due to UMMMC, in order to meet our financial obligations and continue our mission of providing excellent health care to the patients and communities we serve. We are committed to conducting our billing and collection practices in a manner that is fair and respectful of our patients and their families, as outlined below. Patient Financial Services Representatives are available by phone to support patients in resolving their medical bills.

A. Billing Third Party Payors- UMMMC will submit claims for all covered services to a patient's health insurer or other responsible payor if the patient has provided such information timely and accurately. These claims will be submitted as soon as possible after discharge or service date. Patients remain financially responsible for any non-covered services, co-payments, co-insurance amounts, deductibles and/or other amounts owed under the terms of their benefits plan as determined by their health insurer. Patients are responsible for understanding and complying with the referral, authorization and other coverage requirements of their insurer. Patients are also responsible for payment of any services denied by their insurer to the extent permitted by contract and regulation.

UMMMC's Patient Accounting Department will make all reasonable efforts to resolve accounts with third party payors, including the appeal of denied claims. Reports of outstanding accounts will be routinely generated, reviewed by Patient Accounting Staff and Management, and pursued with the payors. If, despite such efforts, UMMMC has not received payment or other appropriate resolution from a non-contracted payor, within a reasonable amount of time, a letter may be sent to the patient informing him/her that the insurer has failed to resolve the claim. If the account remains unpaid by a non-contracted payor, the patient may be subject to the standard Self-Pay Billing and Collection Process to the extent permitted by law. UMMMC will make the same effort to collect accounts for emergency care for uninsured patients as it does to collect accounts for non- emergency care, subject to the terms of this Policy and applicable law.

B. Self-Pay Billing and Collection Process

1. Patients with Self-Pay responsibilities will receive an initial bill clearly delineating the services for which they are responsible.
2. For any Self-Pay responsibilities that remain unpaid after the initial bill, the patient will receive a series of monthly statements for at least 3 months or until the balance is resolved. The last statement will indicate that it is a final notice. A final notice by certified mail will be sent to the patient for balances over $1,000 for emergency care.
3. When a patient statement is returned for an undeliverable address, UMMMC will attempt to call the patient for a correct address on all balances over $1,000. All balances are sent to a vendor to scrub and attempt to locate a correct address using databases such as the NCOA (National Change of Address Association).

4. Patient Accounting Staff or designees will make a telephone call to any patient with an outstanding Self-Pay balance of $1,000 or more during the normal Self-Pay billing and collection process.
5. Additional notices and/or letters may be sent to debtor patients during the billing and collection process in an effort to resolve outstanding balances.
6. All such efforts to collect balances, as well as any patient initiated inquiries, will be documented in the computerized billing system and available for Management review.
7. If after all the above actions, and if the provider accounting and financial clearance departments have exhausted all efforts to determine if a patient meets the eligibility criteria to participate in the UMass Memorial Medical Centers Financial Assistance program, will any of the actions below be taken.
8. Accounts that remain unresolved after 120 days and the collection efforts described above will be reviewed for write-off as Bad Debts, as follows:

Balance	Review Level
$0-$999	Collector
$1,000-$10,000	Supervisor
$10,001-$50,000	Manager
$50,000 and above	Sr. Director

9. UMMMC will check the MassHealth Eligibility Verification (EVS) System for coverage prior to submitting claims to the Health Safety Net Office for emergency bad debt coverage of an emergency or urgent care service.
10. External Billing / Collection Agencies- UMMMC may utilize outside billing and collection agencies to augment efforts to resolve outstanding receivables, and / or transfer Bad Debt Accounts to external collection agencies for further pursuit.

    - UMMMC will not "sell" patient debt to any third party agency.
    - All billing collection agencies working on behalf of UMMMC will commit in writing to abide by collection practices and standards approved by UMMMC and applicable law.
    - UMMMC, may, with Board of Trustees approval and a 30-day written notice provided to the patient, report to a credit rating service debt that remain unpaid after all reasonable attempts to identify available health care coverage, access discount programs and / or establish payment plans as described in this policy have been exhausted. Under no circumstances will patients who have met the State's criteria as Low Income Patients be considered for referral to a credit rating service.

11. Medicare co-insurance, co-payments and deductibles that are deemed to be bad debt will be handled in accordance with the self-pay billing and collection process as specified above subject to applicable law. The external collection agencies will pursue further collection efforts for a period of no less than 60 days before returning the accounts to UMMMC as uncollectible.

C. Customer Service- UMMMC employs a staff of Patient Financial Services Representatives to address patient concerns and questions regarding their bills. The staff is available by phone and in person Monday-Friday from 9:00 AM to 4:30 PM.

D. Payment Plans- An individual with a balance of $1,000 or less will be offered at least a one-year payment plan interest free. A patient that has a balance of more than $1,000, after initial deposit, will be offered at least a two-year interest free payment plan. Patients expressing difficulty in meeting their financial obligations (after all coverage options have been exhausted) will be offered a monthly budgeted payment plan with a minimum monthly payment of no more than $25. Longer payment plans may be granted with manager approval. Patients who cease making monthly budgeted payments without establishing an alternative arrangement will be subject to the normal Self-Pay Billing and Collection Processes including referral to an external collection agency.

E. Interest- UMMMC does not assess interest on Self-Pay balances.

F. Deposit Requirements- UMMMC shall not require pre-admission and/or pre-treatment deposits for patients who require emergency or urgent care services or who are determined to be Health Safety Net/Low Income Patients. UMMMC reserves the right to request advance deposits in the following instances:

1. Patients to receive elective cosmetic or non-medically necessary services may be required to pay an amount up to 100% of expected charges prior to service.
2. Patients who do not have verifiable insurance coverage and do not qualify for the Health Safety Net/Low Income Patient status may be required to pay an advance deposit if the service to be performed is of an elective nature. Failure to meet the deposit requirement may result in postponement or deferral of the service with the attending physician's approval.
3. Patients traveling from foreign countries to UMMMC for elective treatment may be required to pay the full estimated bill in advance.
4. Partial Health Safety Net patients may be requested to pay up to 20% of the deductible amount up to $500.00 for non-emergency services.
5. Medical Hardship patients may be requested to pay up to 20% of the deductible amount up to $1,000.00 for non-emergency services.
6. Insured patients with co-insurance, co-payment deductibles or other member liability responsibilities under their benefit plan design may be requested to pay such amounts, or secure them via a credit card, prior to service.

G. Liens- As a routine course of business, UMMMC will only invoke liens to secure UMMMC's interest in Third Party Settlements or as otherwise required to secure UMMMC's interests during legal proceedings. No liens will be initiated against a patient's primary residence or motor vehicle without prior written approval from UMMMC's Board of Trustees. All approvals by the Board of Trustees will be made on an individual case basis and a 30-day written notice will be provided to patient.

H. Motor Vehicle Accidents/Third Party Liability- UMMMC will submit a claim to the Health Safety Net Office (HSNO) for a Low Income Patient injured in a motor

vehicle accident only after investigating whether the patient, driver and/or owner of the motor vehicle had a motor vehicle insurance policy. UMMMC will make reasonable efforts to obtain any third party insurance information from the patient and retain evidence of such efforts, including documentation of phone calls and letters to the patient. UMMMC will refund the Health Safety Net Office any payment received if any third party resource has been identified and UMMMC receives payment.

I. Bankruptcy- Patients who file for Bankruptcy will have all billing and collection activity discontinued upon receipt of a Notice of Bankruptcy.

J. Patients' Rights and Responsibilities-UMMMC will advise certain patients of their rights and responsibilities at each point where the patient interacts with registration personnel, as noted below.

1. UMMMC will advise patients of the right to:
    a. Apply for MassHealth, a Premium Assistance Payment Program operated by the Health Connector a Qualified Health Plan, Medical Hardship and Health Safety Net determination.
    b. A payment plan, as outlined in our self-pay billing and collection process.
2. Patients who receive Health Safety Net Eligible Services must:
    a. Provide all required documentation.
    b. Inform MassHealth or UMMMC of any change of household/ family income, health insurance and third party liability status.
    c. Track the Annual family deductible as determined for patients with income between 150 % and 300% of the Federal Poverty Income Guidelines and provide documentation to UMMMC that the deductible has been reached when more than one PBFG member is determined eligible or if the patient or family member receives Health Safety Net services from more than one provider.
    d. Notify the Health Safety Net Office or MassHealth in writing within 10 days of filing of any lawsuit or insurance claim that will cover the cost of the services provided by the hospital. A patient is further required to assign the rights to a third party payment to the MassHealth Agency that will cover the costs of the services paid by the Health Safety Net Office or MassHealth and file a claim for compensation.
    e. Repay the Health Safety Net Office any money received from a third party related to an accident or incident for medical service paid by the Health Safety Net Office.
    f. The Health Safety Net Office will recover directly from the patient, only when the patient has received payment from a third party for medical services paid by the Health Safety Net Office
    g. The Health Safety Net Office may request that the Department of Revenue intercept any payments to a patient for services provided for a claim submitted and paid by the Health Safety Net for Emergency Bad Debt

K. Exemption from Self-Pay Billing and Collection Action- UMMMC will not initiate Self-Pay billing and collection activity in the following instances:

1. Upon sufficient proof that a patient is a recipient of Emergency Aid to the Elderly, Disabled and Children (EAEDC), or enrolled in MassHealth, Health Safety Net, the Children's Medical Security Plan whose family income is equal or less than 300% of the FPL or Low Income Patient designation except for Dental-Only Low Income patients as determined by the office of Medicaid with the exception of co-pays and deductibles required under the Program of Assistance.
2. The hospital has placed the account in legal or administrative hold status and/or specific payment arrangements have been made with the patient or guarantor.
3. Medical Hardship bills that exceed the medical hardship contribution.
4. Medical Hardship contributions that remains outstanding during a patient's MassHealth or Low Income Patient eligibility period.
5. Unless UMMMC has checked the EVS system to determine if the patient has filed an application for MassHealth.
6. For Health Safety Net Partial eligible patients, with the exception of any deductibles required.
7. UMMMC may bill for Health Safety Net eligible and Medical Hardship patients for non-medically necessary services provided at the request of the patient and for which the patient has agreed by written consent.
8. UMMMC may bill a Low Income Patient at their request to allow the patient to meet the required CommonHealth One-Time Deductible.