

Boston Children's Hospital  
Credit and Collection Policy

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## **I. General Policy Statement**

In its long tradition of service to the children of Boston, New England and beyond, Boston Children's Hospital (the "Hospital") has always been committed to being a resource for children in need of care, regardless of ability to pay. Each year, thanks to the support the Hospital enjoys from the community and the thoughtful action of the Board of Trustees, the Hospital and its physicians extend millions of dollars in Charity Care to children and families.

The Hospital has a strong commitment to assuring that children have insurance coverage whenever possible. Hospital financial counselors are available to answer families' questions about public coverage available for uninsured children, and to assist families with the completion of necessary applications.

The Hospital evaluates each patient's medical needs and the family's financial status, and tries to be as generous and responsive as possible to all children applying for services. In order to sustain the Hospital's ability to respond to genuine need, sensitive but consistent billing and collection practices are applied to patients and their families. The policies and procedures set forth in this document are adopted in an effort to ensure that billing and collection practices and procedures are reasonable and consistently applied. This Credit and Collection Policy applies to all Boston Children's Hospital sites operated under the Hospital's license.

The Hospital also makes every effort to be flexible and responsive to individual circumstances. In turn, it is expected that families will honor their financial obligations so that the Hospital remains able to provide care for those children whose circumstances in life are less fortunate.

Finally, the Hospital shall not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual orientation, gender identity, age, or disability in its policies or in its application of policies concerning the acquisition and verification of financial information, pre-admission or pretreatment deposits, payment plans, deferred or rejected admissions, or Low Income Patient status as determined by the Office of Medicaid, determination that a patient is low-income, or in its billing and collection practices.

This Credit and Collection Policy is developed to ensure compliance with (1) the Health Safety Net Eligible Services regulation 101 CMR 613.00;

The Centers for Medicare and Medicaid Services Medicare Bad Debt requirements (42 CFR 413.89); and (3) the Medicare Provider Reimbursement Manual (Part I, Chapter 3).

## **II. Definitions**

Charity Care: Hospital or Community Health Center costs for medically necessary services provided to low-income patients that are not eligible for payment from the Health Safety Net Trust Fund or other public or private payment sources. The Hospital also maintains specific Charity Care programs as set forth in policies maintained by the Chief Financial Officer.

Eligible Services: Hospital or Community Health Center charges that are eligible for payment from the Health Safety Net Trust Fund pursuant to regulations promulgated by the Commonwealth of Massachusetts.

Emergency Medical Condition: A medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that 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. § 1395dd(e)(1)(B).

Emergency Services: Medically necessary services provided to an individual with an Emergency Medical Condition.

Low Income Patient: An individual who meets the criteria for determination as a Low Income Patient set forth in Health Safety Net regulations promulgated by the Commonwealth of Massachusetts. In order to be determined a Low Income Patient, an individual must be a resident of the Commonwealth and document family income equal to or less than 400% of the Federal Poverty Level (FPL), and may not be enrolled in MassHealth Standard or MassHealth Family Assistance/Direct Coverage programs; may not have been determined eligible for MassHealth and failed to enroll; and may not have had MassHealth or Commonwealth Care enrollment terminated due to failure to pay premiums.

Medical Hardship: A category of eligibility for coverage of certain charges by the Health Safety Net Trust Fund, for patients/families whose allowable medical expenses have so depleted the family's income that the patient/family is unable to pay for Eligible Services (as defined in regulations). Terms and conditions of Medical Hardship eligibility and payments from the Health Safety Net Trust Fund for services provided to patients eligible for Medical Hardship are specified in regulations promulgated by the Commonwealth of Massachusetts.

Urgent Care: Medically necessary services provided in a hospital or community health center after the 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 be expected to result in: placing a 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. Urgent care services do not include elective or primary care.

### **III. Classification of Services**

Persons may present themselves, or may be presented, for unscheduled treatment in the Hospital's Emergency Department or in other clinical service locations of the Hospital. Any patient presenting for emergency services will be evaluated without regard to the patient's insurance coverage or ability to pay, consistent with the federal Emergency Treatment and Labor Act (EMTALA). After providing services to a patient in the Emergency Department, the treating physician in the Emergency Department classifies the services as Emergency Services or Urgent Care (according to the definitions set forth above), or as Non-Urgent.

Elective services and scheduled services are Non-Urgent, and as such are neither Emergency Services nor Urgent Care, regardless of the setting in which they are provided. These classifications are used by the Hospital for purposes of determining emergency and urgent care bad debt coverage under the Health Safety Net Fund.

The Hospital prohibits any actions that would discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment for emergency medical conditions or permitting debt collection activities that interfere with the provision, without discrimination, of emergency medical care.

### **IV. Help in Obtaining Financial Assistance**

The Hospital will provide to patients, guarantors, or other identified responsible parties information about and assistance with applying for public and other financial assistance programs, including MassHealth, Commonwealth Care, Low Income Patient status according to the Health Safety Net regulations, and other government-sponsored programs, as well as the Hospital's charity care and discounting programs for uninsured patients. The Hospital will make reasonable efforts to provide translator services for patients, guarantors or other responsible parties with limited English proficiency.

The Hospital will assist patients/guarantors in completing applications for public programs. Patients or guarantors must provide documentation required for such applications. The Hospital has no role in the determination of program eligibility, which is made by the Commonwealth. It is the patient's or guarantor's responsibility to inform the Hospital of all coverage decisions made by the Commonwealth and of any change in the patient's eligibility for such programs.

**A. Public Notice of Availability of Financial Assistance.** The Hospital will post signs notifying patients of the availability of financial assistance and of other programs of public assistance and the Hospital location at which patients and families may apply for such assistance. These signs will be posted in inpatient, outpatient and emergency admissions/registration areas as well as business offices customarily used by patients. Posted signs are 8 ½ x 11 inches in size, printed in font size 22, in English and Spanish.

**B. Individual Notice of Availability of Financial Assistance.** The Hospital will provide an individual notice of the availability of financial assistance programs, including Medical Hardship, and assistance in applying for such programs, to any patient expected to incur charges (exclusive of personal convenience items or services) that may not be paid in full by their third party coverage. The Hospital will also include a notice about the availability of financial assistance programs, including Eligible Services to Low Income Patients and other public assistance programs, and the availability of assistance in applying for such programs, in its initial bill and all other written collection actions.

## **V. Deferral/Refusal of Services**

The Hospital will not defer or refuse treatment of patients who present for emergency or urgent care or who are recipients of governmental benefits such as MassHealth, Commonwealth Care, Children's Medical Security Plan, Healthy Start, Health Safety Net, or other public programs, solely due to financial considerations.

The Hospital reserves the right to defer or refuse the provision of non-emergency, non-urgent services to a patient, including in situations in which the patient/family refuses to comply with deposit requirements or lacks resources to pay for services either privately or through third party sources and refuses to apply for available public programs, including MassHealth and Health Safety Net, or refuses to supply required documentation for such application(s).

Whenever the Hospital elects to exercise its right to defer or refuse the provision of services to a patient, and prior to the exercise of that right, the clinician identified as the patient's physician will be contacted to assess the medical/clinical implications of the deferral or refusal of services, and to acknowledge or approve the deferral or refusal of services from a medical/clinical perspective.

In cases in which a patient is denied or refused services, documentation will be retained of the reason for the denial or refusal of services; the patient's physician's assessment of the medical/clinical implications of the deferral or refusal of services and approval from a medical/clinical perspective; and the physician's acknowledgement or approval of the deferral or refusal of services.

## **VI. Procedures for Collecting Patient/Guarantor Financial Information**

**A. Acquisition of Information:** Prior to the delivery of any health care services (except for cases of emergency or urgent care level of service), the patient/guarantor is expected to provide timely and accurate information on their insurance status, demographic information, changes to their family income or insurance status, and information on any deductible or co-payments that are owed based on their existing insurance or financial program's payment obligations. The detailed information will include:

1. Full name, address, telephone number, date of birth, social security number (if available), current health insurance coverage options, citizenship and

residency information, and the patient's/guarantor's applicable financial resources that may be used to pay their bill;

2. Full name of the patient's guarantor, their address, telephone number, date of birth, social security number (if available), current health insurance coverage options, and their applicable financial resources that may be used to pay for the patient's bill; and

3. Other resources that may be used to pay their bill, including other insurance programs, motor vehicle or homeowner's insurance policies if the treatment was due to an accident, worker's compensation programs, and student insurance policies, among others.

It is ultimately the patient's/guarantor's obligation to keep track of and timely pay their unpaid hospital bill, including any existing copayments, co-insurance and deductibles. The patient/guarantor is further required to inform either their current health insurer (if they have one) or the agency that determined the patient's eligibility status in a public health insurance program of any changes in family income or insurance status.

Patients/guarantors are required to notify the state public program (e.g., Office of Medicaid and the Health Safety Net) of information related to 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 right to a third party settlement that will cover the cost of the services paid by the Office of Medicaid or the Health Safety Net.

When the information is not provided at the time an admission or outpatient visit is scheduled, successive attempts will be made to collect the needed information through post discharge/post service.

**B. Data Collection Points:** The following identifies the points at which an attempt to collect this information will be made and by whom:

1. **While scheduling an Admission or Outpatient Visit:** The physician office or hospital staff member scheduling the service will request financial information.
2. **During Verification of Patient Information:** Patient Financial Services staff, physician office or hospital staff verifying patient information prior to service will request financial information.
3. **Day of Admission/Time of Service:** Patient Financial Services, or Patient Care Coordinators as applicable. When any aspect of the patient/guarantor financial information is in question, the patient/guarantor may be referred to Patient Financial Services to clarify the information. This process applies to both scheduled and emergency services (as soon as reasonably practicable after the service or admission, consistent with EMTALA).
4. **During the Hospital Stay:** Patient Financial Services staff or Patient Care Coordinators.
5. **At the Time of Discharge:** Patient Financial Services staff.

**6. Post Discharge/Post Service:** Patient Financial Services staff or financial management agents of the Hospital.

**7. Emergency Services:** Department registration staff will interview, obtain and verify all necessary patient and financial information as soon as permitted by EMTALA regulations. Information not obtained at time of admission will be pursued through patient and/or guarantor contacts and interviews throughout the patient's stay, or at time of discharge if all other attempts are unsuccessful. If authorized by the patient or guarantor, contacts to other individuals will be made to obtain information to assess their ability to pay for services provided.

**8. Validation of MassHealth Eligibility:** For services provided to an uninsured patient, Patient Financial Services staff will check through the MassHealth EVS system and/or the Virtual Gateway maintained by the Massachusetts Executive Office of Health and Human Services whether the patient is eligible for or has submitted an application for MassHealth, Commonwealth Care, or other programs.

C. Hospital Verification of Patient **Financial** Information: **Patient Financial Services staff, clinical department administrative staff, or Patient Care Coordinators will make reasonable and diligent efforts to verify patient-supplied financial information** as soon as possible after it is provided, until the time of discharge or provision of an outpatient service. If information cannot be verified prior to that time, the Patient Financial Services Department or its agents may attempt to verify the information during the billing and collection process.

Given the age of the Hospital's patient population, it is typically the parent or guardian supplying patient insurance and financial information. If additional information is required while the patient is in the Hospital, Patient Financial Services staff members or Patient Care Coordinators contact the patient's primary care nurse or his or her designee for permission to contact the patient or the patient's family.

The Hospital's reasonable and diligent efforts will include, but are not limited to, requesting information about the patient's insurance status, checking any available public or private insurance databases, following the billing rules of a known third party payer, and appealing a denied claim when the service is payable in whole or in part by an insurer.

The Hospital will also make reasonable and diligent efforts to investigate whether a third party resource may be responsible for the services provided by the Hospital, including but not limited to: (1) a motor vehicle or homeowner's liability policy, (2) general accident or personal injury protection policies, (3) worker's compensation programs, and (4) student insurance policies, among others. Hospital will inform patients of their responsibility to inform the appropriate public program of any changes in income or insurance status. In accordance with applicable state regulations or the insurance contract, for any claim where the Hospital's reasonable and diligent efforts resulted in a recovery on the health care claim billed to a private insurer or public program, the Hospital

will report the recovery and offset it against the claim paid by the private insurer or public program. If the Hospital has prior knowledge and is legally able, it will attempt to secure assignment of a patient's right to third party coverage of services provided due to an accident

**D. Release of Information/Assignment of Benefits:** The patient/guarantor may be requested to sign an assignment of insurance benefits or other third party payment sources (e.g., payments resulting from tort actions) directly to the Hospital for services provided, and an authorization to release information as necessary to accomplish the assignment of those benefits. The authorization shall also indicate that the patient/guarantor may be financially responsible for charges not covered by the assignment.

**E. Confirming Financial Responsibility for Non-covered Services:** When an authorization required by the patient's insurer has not been obtained prior to the service, the patient/guarantor will be requested to sign a statement acknowledging that he or she has been notified of the absence of the required authorization and informing him or her of his or her potential financial responsibility for services ultimately determined to be non-covered services.

## VII. Payment

In general, payment in full is expected upon receipt of a bill from the Hospital.

### A. Deposits

**1. Emergency Services:** The Hospital will not require a pretreatment deposit from any patient or guarantor as a condition of receiving emergency care, regardless of the patient's or guarantor's ability to pay.

**2. Non-Emergency Services:** The Hospital may require a preadmission deposit for non-emergent inpatient or outpatient services from a patient (or the patient's guarantor) who lacks sufficient insurance coverage for the service to be provided, is not exempt from collection actions, and has not entered into a Payment Plan with the Hospital.

**3. Special Provisions for Patients Eligible for Health Safety Net:** No patient determined to be a Low Income Patient will be required to pay a deposit. A patient/guarantor determined to be a Low Income Patient with a deductible requirement may be requested to provide a deposit up to 20% of his or her deductible amount up to \$500. A patient/guarantor eligible for Medical Hardship may be requested to provide a deposit up to 20% of his or her Medical Hardship contribution up to \$1000. All remaining balances will be subject to the payment plan conditions established in 101 CMR 613.08

**B. Discounts:** Discounts on patient accounts are not eligible for and will not be submitted to the Health Safety Net. The Hospital offers discounts of up to 40% off charges to uninsured individuals, depending upon timeliness of payment.



Discounts are not available on copayment and deductible amounts. The Hospital's Discounting Policies are maintained by the Chief Financial Officer.

**C. Payment Plans:** In the event that a patient/guarantor cannot pay his or her Hospital bill upon receipt and is determined not to be eligible for Health Safety Net or other applicable public programs, the Hospital may offer the patient/guarantor an arrangement for payments over an extended period of time.

The Hospital will offer patients with a balance of \$1,000 or less, after initial deposit, at least a one-year payment plan interest free with a minimum monthly payment of no more than \$25. Patients with a balance of more than \$1,000, after initial deposit, will be offered an interest free payment plan of at least two years. In cases of extraordinary circumstances, requests for payment plans over two years will be considered on a case-by-case basis. The Hospital shall not require any payment plan for patients who are fully exempt from collection action under this Credit and Collection policy.

The Hospital and its licensed satellite locations, including Martha Eliot Health Center, do not offer deductible payment plans for patients eligible for Health Safety Net – Partial.

**D. Account Adjustment Approval Authority:** Administrative adjustments to accounts and refunds to patients/guarantors or other payers in the amounts noted below may be authorized by the individuals noted below:

1. Up to \$1000: Supervisor, Patient Financial Services
2. Up to \$10,000: Manager, Patient Financial Services
3. Up to \$50,000: Director, Patient Financial Services
4. \$50,000 or more: Chief Financial Officer

### **VIII. Billing, Collection Practices and Bad Debt Determination**

The Hospital applies the same continuous billing and collection efforts to all accounts for uninsured patients as it does to accounts for any other patient classification.

**A. Eligible Service Determinations.** The Hospital follows regulations and guidelines issued by the Commonwealth of Massachusetts in the administration of the Health Safety Net claim eligibility and other programs of public assistance.

The Hospital maintains compliance with applicable billing requirements, including the Department of Public Health regulations (105 CMR 130.332) for non-payment of specific services or readmissions that the Hospital determines were the result of a Serious Reportable Event (SRE). SREs that do not occur at the Hospital are excluded from this determination of non-payment. The Hospital also does not seek payment from a Low Income Patient determined eligible for the Health Safety Net program whose claims were initially denied by an insurance program due to an administrative billing error by the Hospital. The Hospital further maintains all information in accordance with applicable federal and state privacy, security and ID theft laws.

**B. Patients/Guarantors Exempt from Collection Actions:** The Hospital does not bill or otherwise engage in collection action with regard to any patient who establishes that he or she is:

1. Enrolled in MassHealth, receiving benefits under the Emergency Aid to the Elderly, Disabled and Children program, or a participant in the Healthy Start program (except that the Hospital may bill such patients for co-payments and deductibles required under these programs of assistance). The Hospital may initiate billing for a patient who alleges that he or she is a participant in any of these programs but fails to provide proof of such participation; upon receipt of such proof (including receipt or verification of a signed application), the Hospital shall cease collection activities.
2. A participant in the Children's Medical Security Plan (CMSP) whose family income is equal to or less than 400% of the Federal Poverty Income Guidelines. The Hospital may initiate billing for a patient who alleges that he or she is a participant in the CMSP but fails to provide proof of such participation; upon receipt of such proof (including receipt or verification of a signed application), the Hospital shall cease collection activities.
3. A Low Income Patient is exempt from collection action for any Eligible Services received during the period for which he or she has been determined to be a Low Income Patient (except for co-payments and deductibles related to such Eligible Services). The Hospital may continue to bill Low Income Patients for Eligible Services rendered prior to their determination as Low Income Patients, but only after their Low Income Patient status has expired or otherwise been terminated.
4. A Low Income Patient with family income between 201-400% FPL is exempt from collection actions for the portion of the bill that exceeds the deductible and may be billed for co-payments and deductible amounts consistent with state regulations.
5. A patient or family eligible for Medical Hardship, with respect to that amount of the bill that exceeds the Medical Hardship contribution (as calculated in accordance with applicable regulations). If a claim already submitted as Emergency Bad Debt becomes eligible for Medical Hardship payment from the Health Safety Net, the Hospital will cease collection activity on the patient for those services.

Low Income Patients are not exempt from collection actions for services other than Eligible Services that are provided at the request of the patient or guarantor and for which the patient or guarantor has agreed to be responsible. The Hospital must obtain the patient or guarantor's written consent to be billed for such services.

**C. Initial Billing:** Except for patients exempt from collection action as specified above, the Hospital will provide an initial bill to the patient/guarantor or a specified third party. The portion of the account for which the patient/guarantor is responsible and for which the patient/guarantor will be billed excludes that amount covered by the Health Safety Net and the portion exceeding the Medical Hardship contribution, as applicable.

**D. Collection Follow-Up:** The Hospital uses external agencies to perform collection activities on self-pay accounts, and holds any such agency to the standards specified in the Hospital's Patient Financial Services policies on collection practices in effect from time to time, which shall be consistent with this Credit and Collection Policy. All self-pay accounts will be subject to continuous collection activity and will receive a minimum of three collection actions. Collection actions by the Hospital or its designated agent may include, but are not restricted to, the following:

1. Initial bill
2. Statements (sent every 30 days following the determination of a self-pay liability)
3. Follow-up letter (sent via first class mail or certified mail)
4. Telephone calls
5. Meetings with guarantor or other responsible party

**E. Returned Mail:** Accounts for which returned mail is received will be investigated to locate the patient and/or guarantor. Efforts to obtain a current address will include, at a minimum:

1. Review of all inhouse records and appointments to determine if a more current address is documented;
2. Contact with any known relatives or friends; and
3. Review of current telephone directory.

The Hospital may engage outside agencies to perform additional skip tracing activities. Documentation of efforts to locate the party responsible for the obligation will be retained.

**F. Bankruptcies:** Upon receipt of legal notification of the patient's/guarantor's bankruptcy, all collection activity will cease and the account will be adjusted. Bankruptcy cases will not be eligible for and will not be submitted to the Health Safety Net.

**G. Bad Debt Determination:** After reasonable collection efforts have failed to yield payment of charges on an account, the balance on the account may be classified as bad debt in accordance with this Credit and Collection policy and any other applicable finance department policies (which shall not be inconsistent with this Credit and Collection Policy).

Conditions for Immediate Bad Debt Determination: When information is obtained to designate an account as bad debt at any time during the follow-up collection process, the account may be immediately considered as bad debt without any further collection action. Included in this category are the following:

1. Unsuccessful attempt to identify the cause for failure of delivery of mail that is returned as undeliverable. Undeliverable or "bad address" accounts are categorized for follow-up by the mail personnel in Patient Financial Services staff and researched for correct address/contact prior to placing the account in a bad debt status. Follow-up activities are documented.
2. Unsuccessful attempt to identify a working telephone number after patient's/guarantor's telephone has been disconnected.

3. Written or verbal notification of the patient's/guarantor's unwillingness or refusal to pay.
4. Receipt of official notification from an insurance company that benefits were paid to the subscriber, and at least one unsuccessful attempt has been made to contact the patient/guarantor after such notification from the insurer.

**H. Billing Emergency Services Bad Debt to the Health Safety Net:** In addition to following the collection practices outlined above, the Hospital will send a certified letter to any patient (except a patient for whom notices have been returned as “undeliverable” or “incorrect address”) with an outstanding balance of more than \$1,000 in emergency and related services before billing the balance to the Health Safety Net. The balance of the account will be billed to the Health Safety Net only after it has remained unpaid for more than 120 days from the date of the initial billing notice, and reasonable collection efforts undertaken during that period will be documented in the patient's financial record. For services provided to an uninsured patient, Patient Financial Services staff will validate through the MassHealth EVS system and/or the Virtual Gateway that the patient is either not eligible for or has not submitted an application for MassHealth and that the patient is not a Low Income Patient.

**I. Bad Debt Authorization Criteria:** Authorization to classify any account as bad debt varies according to the amount of charges on the account, as follows:

1. Up to \$5000: Supervisor, Customer Service/Self Pay
2. Up to \$10,000: Manager, Customer Service/Self Pay
3. Up to \$50,000: Director, Patient Financial Services
4. \$50,000 or more: Chief Financial Officer

**J. Extraordinary Collection Efforts and Legal Execution:** In general, the Hospital does not undertake “extraordinary collection actions”. Extraordinary collection actions include selling debt to another provider, reporting adverse information about an individual to a consumer credit reporting agency or credit bureau, deferring or denying, or requiring a payment before providing, medically necessary care because of an individual's nonpayment of one or more bills for previously provided care under the Hospital's Financial Assistance policy, placing a lien on or foreclosing on an individual's personal residence or motor vehicle property, garnishing wages, and/or filing a civil action. Any decisions to execute on any extraordinary collection actions shall require a Board of Trustee vote. The Hospital and its agents would be required to demonstrate to the Board of Trustees reasonable efforts have been made to determine a patient's eligibility for assistance under its Financial Assistance Policy prior to recommending extraordinary collection actions. Extraordinary Collection Actions would not be initiated until at least 120 day from the date the Hospital provides the first post-discharge billing statement for the care, and would require demonstration of written notification to the patient of the availability of financial assistance at least 30 days prior to execution. The written notification would need to also indicate the extraordinary collection activity the Hospital would intend to initiate, as well as a start date for the activity. In the event of executed extraordinary collection

actions, the Hospital would suspend all actions in the event a Financial Assistance Application is received to enable a period of review not to exceed 30 days.

Prior to seeking legal execution, the Hospital and its agents shall make reasonable efforts to determine a patient's eligibility for assistance under its Financial Assistance Policy. Reasonable effort shall include written notification of the availability of financial assistance that shall include a deadline after which such legal execution may be initiated. Said deadline shall be no earlier than 30 days from notification. Legal execution will not be initiated until at least 120 days from the date the Hospital provides the first post-discharge billing statement for the care.

**K. Documentation:** The Hospital will document the activity involved in classifying and reporting of an account as bad debt. As the Hospital maintains a "paperless" system for handling both inpatient and outpatient accounts, documentation of activity for these services may be maintained on the Hospital's computer system in comprehensive notes as opposed to on paper.

**L. Motor Vehicle Accidents:** The Hospital will submit a claim for Eligible Services provided to a Low Income Patient injured in a motor vehicle accident only if (1) it has investigated whether the patient, driver, and/or owner of the other motor vehicle had a motor vehicle liability policy; (2) has made every effort to obtain the third party payer information from the patient; (3) has retained evidence of such efforts, including documentation of phone calls and letters to the patient; and (2) where applicable, it has properly submitted a claim for payment to the motor vehicle liability insurer. For motor vehicle accidents and all other recoveries on claims previously billed to the Health Safety Net, the Hospital will report any recovery to the Health Safety Net Office. The recovery will be offset against the claim for Eligible Services.

## **IX. Patient Rights and Responsibilities**

- A. The Hospital must advise patients of the right to:
  - 1. Apply for MassHealth, Commonwealth Care, Low Income Patient determination and Medical Hardship; and
  - 2. A payment plan, as described in this Credit and Collection Policy and applicable regulations, if the patient is determined to be a Low Income Patient or qualifies for Medical Hardship.
  
- B. A patient who receives Eligible Services must:
  - 1. Provide all required documentation;
  - 2. Inform MassHealth of any changes in Family Income or insurance status, including but not limited to income, inheritances, gifts, and distributions from trusts, the availability of health insurance and third-party liability. The patient may, in the alternative, provide such notice to the Hospital; and
  - 3. Track the patient Deductible and provide documentation to the Hospital that the deductible has been reached when more than one family member is

determined to be a Low Income Patient or if the patient or family members receive Eligible Service from more than one provider; and

4. Inform the Division of Health Care Finance and Policy or MassHealth when the patient is involved in an accident, or suffers from an illness or injury, or other loss that has or may result in a lawsuit or insurance claim. The patient must:

a. File a claim for compensation;

b. Agree to comply with all requirements of M.G.L. ch. 118G, including but not limited to:

(1) assigning to the Division the right to recover an amount equal to the Health Safety Net payment provided from the proceeds of any claim or other proceeding against a third party;

(2) providing information about the claim or any other proceeding, and fully cooperating with the Division or its contractor, unless the Division determines that cooperation would not be in the best interests of, or would result in serious harm or emotional impairment to, the patient;

(3) notifying the Division or MassHealth in writing within 10 days of filing any claim, civil action, or other proceeding; and

(4) repaying the Health Safety Net from the money received from a third party for all Health Safety Net eligible services provided on or after the date of the accident or other incident after becoming a Low Income Patient for purposes of Health Safety Net payment, only Health Safety Net payment provided as a result of the accident or other incident will be repaid.

c. The Division only recovers sums directly from a patient to the extent that the patient has received payment from a third party for the medical care paid by the Health Safety Net or to the extent specified in 101 CMR 613.06(5)