

Credit and Collection Policy

Purpose

This Credit and Collection Policy describes the billing, credit and collection practices applicable to patients of The Children's Hospital Corporation d/b/a Boston Children's Hospital (the "Hospital"). A list of the Hospital practices, locations and other sites that provide Emergency Services and Medically Necessary Services to which this Credit and Collection Policy applies is available as described in this Credit and Collection Policy. In addition, certain provisions of this Credit and Collection Policy, as specifically identified in this Credit and Collection Policy, apply to services provided at Hospital sites, or at the Hospital's related Physician Foundation (the "Foundations") sites where administrative support systems and personnel are provided through the Hospital, by Foundation clinicians. This Policy does not apply to Boston Children's Health Solutions, Rx, LLC d/b/a Boston Children's Pharmacy or any items provided by Boston Children's Health Solutions, Rx, LLC d/b/a Boston Children's Pharmacy.

Policy Statements

1. The Hospital and the Foundations are committed to being resources for children in need of care, regardless of ability to pay.
2. This Credit and Collection Policy applies to all Emergency Services and other Medically Necessary Services (as defined below) provided by the Hospital. In addition, certain provisions of this Credit and Collection Policy apply to Medically Necessary Services provided by the Foundations at certain Foundation sites. Emergency Services and other Medically Necessary Services do not include elective cosmetic procedures.
3. The Hospital will provide Emergency Services to all patients, without discrimination on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual orientation, gender identity, age, disability, or Low Income Patient (defined below) status, and will apply the policies and procedures described in this Credit and Collection Policy without discrimination. The Hospital prohibits any actions that would discourage individuals from seeking Emergency Services, 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 Services.
4. The Hospital and the Foundations, in accordance with their Financial Assistance Policy, will assist patients/Guarantors (defined below) with the process for completing applications for available Public Health Care Programs (defined below), whenever possible.
5. The Hospital and the Foundations may provide financial assistance to patients who meet the eligibility criteria described in their Financial Assistance Policy.
6. The Hospital and the Foundations will (a) refrain from efforts to collect payment for Emergency Services and Medically Necessary Services (defined below) from

patients who are exempt from collection action under this Credit and Collection Policy (b) refund any collections received from such patients for Emergency Services and Medically Necessary Services; and (c) share information with one another about patients' insurance and eligibility for public or Hospital programs.

7. The Hospital and the Foundations may, in accordance with this Credit and Collection Policy and with their Uninsured Patient Discount Policy, extend discounts beyond those available under their Financial Assistance Policy, on a case-by-case basis, in order to recognize unique cases of financial hardship.

Definitions

Amounts Generally Billed (AGB): The amounts generally billed for Medically Necessary Services to individuals who have insurance covering such Medically Necessary Services. AGB will be calculated using the "Look-Back Method", and as more fully described in the Hospital's Financial Assistance Policy, in the Section entitled "Limitation on Charges".

Countable Income: As defined in the Health Safety Net Regulations.

Eligible Services: Hospital or Community Health Center charges that are eligible for payment by the Health Safety Net pursuant to the Health Safety Net Regulations.

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 average knowledge of health and medicine to result in placing the health of the person or another person in serious jeopardy, serious impairment to bodily function or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further defined in 42 USC Section 1395dd(e)(1)(B).

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

Federal Poverty Level (FPL): Income thresholds issued annually by the United States Department of Health and Human Services.

Guarantor: A person or group of person, including, without limitation, a patient's parents, legal guardians and other family members, who/that assume(s) the responsibility of payment for all or part of the Hospital's or Foundations' charges for services.

Health Safety Net: The payment program established and administered in accordance with M.G.L. c.188E, Section 65.

Health Safety Net Regulations: The regulations set forth at 101 CMR 613.00, et. Seq.

Massachusetts Resident: a resident of the Commonwealth of Massachusetts who meets the criteria set forth in 130 CMR 503.002.

MassHealth MAGI: Modified Adjusted Gross Income used for determining eligibility for MassHealth, including, without limitation, the time periods applicable for measuring MAGI Income to determine MassHealth eligibility.

Medical Hardship: A Health Safety Net eligibility type available to Massachusetts Residents at any Countable Income level whose allowable medical expenses have so depleted his, her or a Guarantor's Countable Income that s/he is unable to pay for Eligible Services, as described in 101 CMR 613.05.

Medically Necessary Services: Services that are reasonably expected to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity.

Non-Covered Services: Non-Covered Services includes services (a) not included as covered benefits/eligible services under the patient's Private Health Plan or Public Health Care Assistance Program, and for which the patient is financially responsible for payment to the provider(s) of such services; (b) included as covered benefits/eligible services, but are provided after the patient has exhausted all benefits under his/her Private Health Plan or Public Health Care Assistance Program; or (c) that are rendered by a provider that is not included in the patient's Private Health Plan's or Public Health Care Assistance Program's network. Non-Covered Services does not include Emergency Services.

Patient Financial Responsibility: All copayments, coinsurance and deductibles required to be paid by the patient/Guarantor under the terms of the Private Health Plan or Public Health Care Assistance Program in which the patient is enrolled or for which the patient has qualified.

Private Health Plan: Coverage for health care services provided under health insurance, health plan or other coverage or under any other health, welfare or other plan, fund or trust established for the purpose of paying for, or otherwise addressing payment for, health care services provided to those enrolled in or under or qualified for such insurance, plan or program.

Provider Affiliates: The individual practitioners, practice groups and other persons and entities who/that provide Emergency Services and other Medically Necessary Services in the Hospital, including in any clinics of the Hospital and any Hospital licenses health centers. A list of the Hospital's Provider Affiliates is available as described in this Credit and Collection Policy.

Public Health Care Assistance Programs: Programs established by a state or federal government to pay or otherwise address the cost of covered/eligible health care services provided to individuals who meet the program's eligibility criteria. Public Health Care Assistance Programs include, but are not limited to, MassHealth, Health Safety Net, subsidized plans offered under the Affordable Care Act, such as ConnectorCare plans, the Children's Health Insurance Program (CHIP), other Medicaid programs and Medicare.

Other Funding: includes other resources and sources of funding held by, available to, or for the benefit of, the patient/Guarantor, which can be used to pay for the patient's care, including, without limitation, through charitable organizations, from relatives, friends and other third parties, and trust funds (including funds available under crowd funding and other similar methods for fundraising).

Urgent Care: Medically Necessary Services provided by the Hospital after the 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 a patient's health in jeopardy, impairment to bodily functions, 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 services.

Classification of Services/Deferral or Refusal of Services

Persons may present themselves, or may be presented, for unscheduled treatment in the Hospital's Emergency Department, or otherwise present themselves, or are presented, on the Hospital's Main Campus, and request examination or treatment for what may be an Emergency Medical Condition, or may have such a request made on his or her behalf. 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 Medical Treatment and Labor Act (EMTALA). After evaluation of 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.

The Hospital prohibits any actions that would discourage individuals from seeking Emergency Services, such as by requiring 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 Services.

In addition, the Hospital will not defer or refuse treatment of patients who present for Emergency Services or Urgent Care or who are enrolled in a Public Health Care Assistance Program, solely due to financial considerations. The Hospital reserves the right to defer or refuse the provision of non-Emergency Services, non-Urgent Care to a patient, including in situations in which the patient/Guarantor refuses to comply with deposit requirements or lacks resources to pay for services either privately through Other Funding, and refuses to apply for or use available Private Health Plan coverage or Public Health Care Assistance Programs available to the patient or for which the patient is eligible, or refuses to supply required documentation for such application(s).

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 Services and Urgent Care), the patient/Guarantor is expected to provide timely and accurate information on the patient's Private Health Plan or Public Health Care Assistance Program coverage and/or eligibility for such coverage; demographic information; changes to status of Private Health Plan or

Public Health Care Assistance Program coverage; and information on any deductible, copayments and coinsurance that are owed based on the patient's existing coverage or other payment obligations. The detailed information may include:

1. Patient's full name, address, telephone number, email address, date of birth, social security number (if available), current Private Health Plan or Public Health Care Assistance Program coverage, citizenship and residency information, and the patient's/Guarantor's financial resources that may be used to pay for the patient's care;
2. Full name of the patient's Guarantor, address, telephone number(s), email address, date of birth, social security number (if available), current Private Health Plan or Public Health Care Assistance Program coverage, and financial resources that may be used to pay for the patient's care; and
3. Other resources that may be used to pay for the patient's care, including, without limitation, Other Funding, 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.
4. Documentation that verifies the information described above.

When the information required or acceptable verification of 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 may 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 may request financial information, if necessary.
3. **Day of Admission/Time of Service; during the Hospital Stay; at the Time of Discharge; and Post Discharge/Post Time of Service:** Patient Financial Services, Patient Care Coordinators, or Care Managers, 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 requirement under EMTALA).
4. **Emergency Services:** Emergency Department registration staff will interview, obtain and verify all necessary patient and financial information, as soon as permitted under EMTALA regulations. Information not obtained at time of service or admission will be requested through patient/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/Guarantor, contacts to other individuals will be made to obtain information to assess the patient's/Guarantor's ability to pay for services provided.

In addition, patients/Guarantors may provide information using the Hospital's patient portal or one of the Hospital's check in kiosks, which are located in various areas in the Hospital.

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. For services provided to an uninsured patient, Patient Financial Services staff will check, through the MassHealth program's and/or the Massachusetts Executive Office of Health and Human Services' verifications systems, whether the patient is eligible for or has submitted an application for MassHealth, ConnectorCare, or other Public Health Care Assistance programs. If information cannot be verified prior to the time of discharge or provision of an outpatient service, the Patient Financial Services Department or its agents may attempt to verify the information during the billing and collection process.

The Hospital's reasonable and diligent efforts to verify patient information will include, but are not limited to, requesting information about the patient's coverage and eligibility for coverage; checking any available public or private health plan databases; verifying liability of a known third party payer; submitting claims to all responsible health plans identified, and complying with such health plans' billing and authorization requirements, 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. Upon identification of a responsible third party resource with respect to any services for which the Hospital has received payment from the Health Safety Net program, the Hospital will return such payment to the Health Safety Net program. The Hospital will inform patients of their responsibility to inform the appropriate Public Health Care Assistance Program of any changes in income or insurance status.

D. Release of Information/Assignment of Benefits: The patient/Guarantor may be requested to sign an assignment of 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 Private Health Plan, Public Health Care Assistance Program, or other responsible payer has not been obtained prior to the provision of services, or when a service is not covered under the patient's Private Health Plan or Public Health Care Assistance Program coverage, including, without limitation, when the Hospital or physician is not an in network provider under the patient's Private Health Plan or Public Health Care Assistance Program coverage, the patient/Guarantor will be required to sign a statement acknowledging that s/he has been notified of the absence of the required authorization or the lack of coverage for the services, and informing him/her of his/her financial responsibility for services ultimately determined to be Non-Covered Services.

If it is determined at any time during the patient's course of treatment that the patient/Guarantor is unable to pay, the patient/Guarantor who is unable to pay for

services provided will be referred to the Hospital's financial counselors for assistance with identifying any Private Health Plans or Public Health Care Assistance Programs for which they may be eligible, and any financial assistance and/or discount programs for which they may qualify.

Payment

In general, payment in full is expected upon receipt of a bill from the Hospital. It is ultimately the patient's/Guarantor's obligation to keep track of and timely pay the unpaid bills for care received by the patient from the Hospital, including any existing copayments, co-insurance and deductibles.

A. Deposits/Patient Financial Responsibility

1. **Emergency Services:** The Hospital will not require a pretreatment deposit, or payment of any Patient Financial Responsibility from any patient/Guarantor as a condition of receiving Emergency Services, regardless of the patient's/Guarantor's ability to pay.
2. **Non-Emergency Services:** The Hospital may require a preadmission deposit or payment of any Patient Financial Responsibility for non-emergent inpatient or outpatient services from a patient/Guarantor, if the patient lacks sufficient coverage for the services 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 Who Have Qualified for coverage under the Health Safety Net Program:** No patient determined to be a Low Income Patient will be required to pay a deposit, except as follows: (a) A patient determined to be a Low Income Patient with a deductible requirement may be required to provide a deposit up to 20% of the amount of his/her deductible, up to \$500; and (b) A patient eligible for Medical Hardship may be required to provide a deposit up to 20% of his/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% of charges to uninsured patients, depending upon timeliness of payment, in accordance with the Hospital's Uninsured Patient Discount Policy. Eligibility criteria and other terms related to uninsured patient discounts are described in the Hospital's Uninsured Patient Discount Policy, which is available to patients through the Hospital's Financial Counselors, and at www.childrenshospital.org/financialassistance.

C. Payment Plans: In the event that a patient/Guarantor cannot pay the Hospital's bill, upon receipt, for care provided to the patient, and the patient is determined not to be eligible for Health Safety Net or other applicable Private Health Plan coverage or Public Health Care Assistance Programs, and does not qualify for financial assistance under the Hospital's Financial Assistance Policy, the Hospital may offer the patient/Guarantor an arrangement to make payments over an extended period of time.

1. The Hospital will offer Low Income Patients and patients who qualify for Medical Hardship, with a balance of \$1,000 or less, after initial deposit, at least a one-year, interest-free payment plan, with a minimum monthly payment of no more than \$25. Low Income Patients and patients who

qualify for Medical Hardship, with a balance of more than \$1,000, after initial deposit, will be offered a two-year, interest-free payment plan. In cases of extraordinary circumstances, requests for payment plans over two years will be considered on a case-by-case basis.

2. For all other patients/Guarantors, in cases of extraordinary circumstances, the Hospital may offer payment plans of such amounts and durations as are appropriate to the circumstances, on a case-by-case basis.
3. The Hospital does not generally offer a deductible payment plan for outpatient services.

Help to Apply for Financial Assistance

The Hospital will provide information to patients/Guarantors about, and assistance with applying/qualifying for, Public Health Care Assistance Programs and other financial assistance programs, including MassHealth, Connector Care, qualification as a Low Income Patient under the Health Safety Net Regulations, and other Medicaid programs, as well as the Hospital's Financial Assistance and Uninsured Patient Discount programs. The Hospital will make reasonable efforts to provide translator services for patients and Guarantors with limited English proficiency.

Patients/Guarantors must provide all documentation required for such applications. The Hospital has no role in the determinations of eligibility for Public Health Care Assistance Programs, which are made by the agencies responsible for administering those programs. It is the patient's/Guarantor's responsibility to inform the Hospital of all coverage determinations made by those agencies, 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 assistance offered by the Hospital to facilitate the patient's application for other Public Health Care Assistance Programs, and the Hospital locations 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 in business offices customarily used by patients.

B. Individual Notice of Availability of Financial Assistance. The Hospital will provide, (i) during the patient's initial registration with the Hospital; (ii) on all billing invoices and in other written collection actions; and (iii) when the Hospital becomes aware of a change in the patient's eligibility or health care coverage, an individual notice of the availability of financial assistance and Eligible Services (as defined in the Health Safety Net Regulations) and other Public Health Care Assistance Programs, and may provide assistance in applying for such programs, to any patient who seeks such assistance.

C. Electronic Access to Credit and Collection and Other Policies.

Patients/Guarantors can access copies of this Credit and Collection Policy, and the Hospital's and the Foundations' Financial Assistance Policy and Uninsured Patient Discount Policy, as well as its AGB Calculation and copies of other documents used to notify patients of the availability of assistance, at www.childrenshospital.org/financialassistance.

Billing/Collection Practices; Bad Debt Determinations

The Hospital applies the same continuous billing and collection efforts to all accounts for uninsured patients as it does to accounts for other patients. Copies of the Hospital's standard billing invoices and financial assistance approval/denial letters are available as described in this Credit and Collection Policy

A. Eligible Service Determinations. The Hospital complies with the regulations and guidelines issued by the Commonwealth of Massachusetts in the administration of Health Safety Net claim eligibility and claims submitted under other Massachusetts Public Health Care Assistance Programs.

The Hospital complies with applicable billing requirements, including, without limitation, the Department of Public Health regulations (105 CMR 130.332) regarding 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 for Eligible Services provided to a Low Income Patient or for Covered Services provided to MassHealth enrollees with respect to claims for which payment was initially denied by the Low Income Patient's insurer due to an administrative billing error by the Hospital.

B. Patients/Guarantors Exempt from Collection Actions: The Hospital and the Foundations do not bill or otherwise engage in collection action with respect to Medically Necessary Services provided to any patient who establishes that s/he is:

1. Enrolled in MassHealth, receiving benefits under the Emergency Aid to the Elderly, Disabled and Children program (except that the Hospital may bill such patients for Patient Financial Responsibility under these programs of assistance). The Hospital may initiate billing for a patient who alleges that s/he is a participant in any of these programs but fails to provide proof of such participation; upon receipt of satisfactory proof that the patient is a participant in one or more of these programs, and receipt of a signed application, the Hospital shall cease collection activities.
2. A participant in the Children's Medical Security Plan (CMSP) whose MassHealth MAGI is equal to or less than 400% of the Federal Poverty Level (FPL). The Hospital may initiate billing for a patient who alleges that s/he is a participant in the CMSP but fails to provide proof of such participation; upon receipt of satisfactory proof that a patient is a participant in CMSP, the Hospital shall cease collection activities.
3. A Low Income Patient (other than a dental-only Low Income Patient) is exempt from collection action for any Eligible Services received only during the period for which s/he has been determined to be a Low Income Patient (except for copayments and deductibles related to such Eligible Services). The Hospital may bill Low Income Patients for Eligible Services rendered prior to their determination as Low Income Patients, only after their Low Income Patient status has expired or otherwise been terminated.
4. A Low Income Patient (other than a dental-only Low Income Patient) with MassHealth MAGI or Medical Hardship Family Countable Income (as described in 101 CMR 613.04(2)) of 400% of FPL is exempt from collection actions for the portion of the bill that exceeds the Low Income Patient's deductible, and may be billed for copayments and deductible amounts consistent with state regulations. The Hospital may continue to bill Low Income Patients for

services rendered prior to their determination as Low Income Patients, but only after their Low Income Patient status has expired or otherwise been terminated.

5. A patient who has qualified for Medical Hardship, with respect to that amount of the bill that exceeds the Medical Hardship contribution (as calculated in accordance with applicable Health Safety Net 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 for those services.
6. A patient whom the Hospital or a Foundation was assisting to apply for Medical Hardship, if the Hospital or Foundation, as applicable, failed to submit the patient's application within five (5) business days of completion of the application and provision of all required documentation by the patient/Guarantor to the Hospital or Foundation, with respect to any bills that would have been eligible for Medical Hardship payment had the application been submitted and approved.

Low Income Patients are not exempt from collection actions for services other than Eligible Services that are provided at the request of the patient/Guarantor and for which the patient/Guarantor has agreed to be responsible; provided that Low Income Patients will not be billed for claims related to medical errors or for claims denied by the patient's primary insurer due to an administrative or billing error. The Hospital will obtain the patient/Guarantor's written consent to be billed for such services.

At the request of a patient, the Hospital or Foundation, as applicable, may bill a Low Income Patient in order to allow such patient to meet the required CommonHealth one time deductible.

C. Initial Billing: Except for patients exempt from collection action, as described above, the Hospital will provide an initial bill to the patient/Guarantor or a specified third party.

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 patient accounts not exempt from collection action 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, sent to the patient/Guarantor and any other party or parties responsible for the patient's financial obligations;
2. Additional billing 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, electronic notifications (e.g., via email addresses), personal contact notices;
5. Final notice for balances over \$1,000 (sent via certified mail); and
6. Meetings with Guarantor or other responsible party.

The Hospital will maintain a file for each patient that includes all documentation of the Hospital's collection efforts, including copies of bills, follow-up letters, reports of telephone and personal contacts and other efforts made.

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 in-house 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, vendors and other service providers to perform additional skip tracing activities. Efforts to locate the party responsible for the obligation or the correct address on bills returned as "incorrect address" or "undeliverable" will be documented.

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 will be consistent with this Credit and Collection Policy); provided that Patient Financial Responsibilities are not included in Bad Debt for purposes of making claims under the Health Safety Net.

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 Patient Financial Services staff and researched for correct address/contact prior to placing the account in a bad debt status.
2. Unsuccessful attempt to identify a working telephone number after patient's/Guarantor's telephone has been disconnected.
3. Written or oral notification of the patient's/Guarantor's unwillingness or refusal to pay.
4. Receipt of official notification from an insurer or other responsible payer 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/other responsible payer.

H. Billing Emergency Services Bad Debt to the Health Safety Net: In addition to 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 Services 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. 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's eligibility verification system, 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. 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 or another entity, 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 Services 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 decision to execute any extraordinary collection actions shall require a vote of the Board of Trustees. The Hospital and its agents would be required to demonstrate to the Board of Trustees that 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 days 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. Such an application would enable a period of review not to exceed 30 days.

J. 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 (4) 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.

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.

Patient Rights and Responsibilities

- A.** The Hospital will advise patients of their rights to:
1. apply for MassHealth, the Premium Assistance Payment Program Operated by the Health Connector, a Qualified Health Plan, Low Income Patient determination and Medical Hardship; and
 2. a payment plan, as described in this Credit and Collection Policy and applicable Health Safety Net 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 MassHealth MAGI or Medical Hardship Family Countable Income (as described in the Health Safety Net Regulations) or insurance status, including but not limited to income, inheritances, gifts, and distributions from trusts, the availability of health insurance and third-party liability;
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 Health Safety Net Office or MassHealth Agency 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, if available; and
 - b. agree to comply with all requirements of M.G.L. c. 118E, including, but not limited to:
 - (1) assigning to the Health Safety Net Office 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 Health Safety Net Office or its designee, unless the Health Safety Net Office 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 Health Safety Net Office or MassHealth Agency, 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 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, provided that only Health Safety Net payments provided as a result of the accident or other incident will be repaid.

Publication/Availability of Credit and Collection Policy, Provider Affiliate List, Billing Invoices and Financial Assistance Approval/Denial Letters, Financial Assistance Policy and Plain Language Summary, Uninsured Patient Discount Policy, and Amounts Generally Billed Calculation

A. Patients, Guarantors and other members of the public may obtain a copy of this Credit and Collection Policy, List of Provider Affiliates, Sample Billing Invoices and Financial Assistance Approval/Denial Letters, the Financial Assistance Policy and Plain Language Summary, the Uninsured Patient Discount Policy, and the Amounts General Billed Calculation free of charge by any of the following methods:

1. Internet Posting: This Credit and Collection Policy and other documents are available online at: www.childrenshospital.org/financialassistance.

2. In-Person: Paper copies of the Hospital’s (i) Credit and Collection Policy, (ii) Provider Affiliate List, (iii) copies of billing invoices and financial assistance approval/denial letters, (iv) Financial Assistance Policy and a Plain Language Summary, (v) Amounts Generally Billed Calculation, and (vi) Uninsured Patient Discount Policy, are available at the Hospital facility located at 300 Longwood Avenue, Boston, MA, Farley Building room 160.
 3. By Mail: The public may also request copies of these documents by mail by calling Patient Financial Services Customer Support at (617)-355-3397 and/or Patient Financial Counseling at 617-355-7201.
- B. Foreign language translations of this Credit and Collection Policy, Financial Assistance Policy, the Financial Assistance Policy Plain Language Summary, the Financial Assistance Application, the Uninsured Patient Discount Policy and the Amounts Generally Billed Calculation are available in several languages to assist those with limited English proficiency.
- C. On-site Communication: The Hospital will make efforts to communicate its Credit and Collection policies through several methods.
1. Signs will be placed in inpatient, clinic and admission/registration, areas regarding the availability of financial assistance and its Credit and Collection policies.
 2. Public displays or other measures reasonably calculated to attract visitors’ attention will be conspicuously posted at various locations throughout the Hospital, including, without limitation, at inpatient, clinic and emergency admission/registration areas.
 3. Copies of this Credit and Collection Policy will be offered to all patients either at time of admission or as part of the discharge process.

Additional/Related Documents, Policies and Programs

1. List of Provider Affiliates
2. Samples of billing invoices and financial assistance approval/denial letters
3. Financial Assistance Policy
4. Plain Language Summary for Financial Assistance Policy
5. Financial Assistance Application
6. Uninsured Patient Discount Policy
7. International Patient Financial Assistance Program

Document Attributes

Title	Credit and Collection Policy		
Authors	Director of Tax and Financial Regulatory Compliance	Effective Date	9/30/2016
Reviewed/ Revised by	Stella Parry, Lead General Counsel, Boston Children’s Hospital Paul Pecoraro, Vice President, Patient Financial Services, Boston Children’s Hospital	Dates Reviewed/ Revised:	12/7/2021 12/10/2021

Approved	12/20/2021	Effective Date	1/1/2022
	Boston Children's Hospital Board of Trustees' delegates		