Cambridge Health Alliance

Financial Assistance Policy

March 1st, 2025

Cambridge Health Alliance

Financial Assistance Policy

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Introduction

This policy applies to **The Cambridge Health Alliance** and its specific locations and providers identified in this policy.

The hospital is the frontline caregiver providing medically necessary care for all people who present to its facility and locations regardless of ability to pay. The hospital offers this care for ***all*** patients that come to our facility 24 hours a day, seven days a week, and 365 days a year. The hospital is committed to providing all of our patients with high-quality care and services including working with individuals whose resources and income are limited to find available options to cover the cost of their care.

The hospital will help uninsured and under-insured individuals enroll for health coverage through a public assistance program. These programs typically include, but not limited to:

- MassHealth
- Premium assistance plans offered by the Health Connector
- Children's Medical Security Program (CMSP)
- Health Safety Net (HSN)
- Medical Hardship.

Assistance for these programs is determined by reviewing, among other items, an individual's household income, assets, family size, expenses, and medical needs.

While the hospital assists patients in obtaining health coverage through public programs, the hospital may also be required to appropriately bill and collect for specific balances to the patient for payments. These balances may include, but are not limited to, any applicable co-payments, deductibles, deposits, and other amounts for which the patient agrees to be responsible. When registering for services, or upon receipt of a bill, the hospital encourages all patients to contact our Financial Assistance Department to help them or their family members determine their needs and eligibility for financial assistance.

The hospital works with patients to find available public assistance and does 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;
- acquisition and verification of financial information;
- preadmission or pretreatment deposit requirements;
- payment plans;
- deferred or rejected admissions;
- determination of a Low Income Patient status as determined by the Massachusetts MassHealth/Connector eligibility system, or attestation of information to determine Low Income patient status.

While we understand that each individual has a unique financial situation, information and assistance about eligibility for public assistance programs may be obtained by contacting the hospital's Financial Assistance Department at 617-665-1100, or in person Monday to Friday between the hours of 8:00am to 6:00pm (hours may vary) at the following locations:

- The Cambridge Hospital at 1493 Cambridge Street, Cambridge, Massachusetts, 02139
- Somerville Hospital, 230 Highland Avenue, Somerville, Massachusetts, 02143
- Everett Hospital, 103 Garland Street, Everett, Massachusetts, 02149

More information about how to apply for health insurance is available at the hospital's website:

- **www.challiance.org**
- Affiliates: Beth Israel Deaconess Center, MassGeneral Hospital for Children, Harvard Medical School Teaching Hospital

The actions that the hospital may take in the event of nonpayment are described in the separate hospital Billing and Collections Policy and which is available upon request.

Coverage for Medically Necessary Health Care Services

The hospital provides medically necessary medical and behavioral health care services for all patients who present at a hospital location regardless of their ability to pay. Medically necessary services includes those 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. Medically Necessary Services include inpatient and outpatient services as authorized under Title XIX of the Social Security Act.

The treating medical professional will determine the type and level of care and treatment that is necessary for each patient based on their presenting clinical symptoms and following applicable standards of practice. The hospital follows the federal Emergency Medical Treatment and Active Labor Act (EMTALA) requirements by conducting a medical screening examination for patients who present at a hospital location seeking emergency services to determine whether an emergency medical condition exists.

Classification of emergency and non-emergency services is based on the following general definitions, as well as the treating clinician's medical determination. This classification is further used by the Hospital for the purposes of determining allowable emergency and urgent bad debt coverage under the hospital's financial assistance program, including the Health Safety Net.

A. Emergency and Urgent Care Services

Any patient who presents at a hospital requesting emergency assistance will be evaluated based on the presenting clinical symptoms without regard to the patient's identification, insurance coverage, or ability to pay. The hospital will not engage in actions that discourage individuals from seeking emergency medical care, such as demanding that patients pay before receiving

treatment for emergency medical conditions, or interfering with the screening for and providing of emergency medical care by first discussing eligibility for public assistance programs.

a. Emergency Level Services includes treatment for:
    i. A medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, such *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 bodily functions, or serious dysfunction of any bodily organ or part,* or, with respect to a pregnant woman, as further defined in 42 U.S.C. § 1395dd(e)(1)(B).
    ii. In accordance with federal requirements, EMTALA is triggered for anyone who presents to a hospital's property requesting examination or treatment of an emergency (as defined above) 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/outpatient unit, clinic, or other ancillary area will also be evaluated for and possibly transferred to a more appropriate location for 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 level care. The determination that there is an emergency medical condition is made by the treating clinician or other qualified medical personnel of the hospital as documented in the hospital medical record.

b. Urgent Care Services include treatment for the following:
    i. Medically Necessary Services provided in an Acute Hospital after the sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) such *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 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 Primary or Elective Care.

B. Non-Emergent, Non-Urgent Services:

For patients who (1) the treating clinician determines is non-emergent or non-urgent level care or (2) seek care and treatment following stabilization of an emergency medical condition, the hospital may deem that such care is primary or elective services.

a. Primary or Elective Services includes medical care that is not an Urgent or Emergency level of care and is required by individuals or families for the

maintenance of health and the prevention of illness. Typically, these services are medical or behavioral health procedures/visits scheduled in advance or on the same day by the patient or by the health care provider at a hospital location including but not limited to the main campus, a remote site or location, as well as an affiliated physician office, clinic, or community health center. Primary Care consists of health care services customarily provided by general practitioners, family practitioners, general internists, general pediatricians, and primary care nurse practitioners or physician assistants in a primary care service. Primary Care does not require the specialized resources of an Acute Hospital emergency department and excludes Ancillary Services and maternity care services.

b. Non-emergent or non-urgent health care services (i.e., primary or elective care) may be delayed or deferred based on the consultation with the hospital's clinical staff, as well as the patient's primary care or treating provider if available and as appropriate. The hospital may further decline to provide a patient with non-emergent, non-urgent services if the patient is medically stable and the hospital is unable to obtain from the patient or other sources appropriate payment source or eligibility information for a public or private health insurance to cover the cost of the non-emergent and non-urgent care. Coverage for healthcare services, including medical and behavioral health, is determined and outlined in a public and private health insurer's medical necessity and coverage manuals. While the hospital will attempt to determine coverage based on the patient's known and available insurance coverage, it may bill the patient if the services are not a reimbursable service and the patient has agreed to be billed.
c. Coverage from a public program may not apply to certain primary or elective procedures that are not reimbursable by such coverage options. If the patient is not sure if a service is not covered, they should contact Financial Assistance Department at 617-665-1100, or in person Monday to Friday between the hours of 8:00am to 6:00pm (hours may vary) at the following locations:

    - The Cambridge Hospital, 1493 Cambridge St, Cambridge, Massachusetts, 02139
    - Somerville Hospital, 230 Highland Ave, Somerville, Massachusetts, 02143
    - Everett Hospital, 103 Garland St, Everett, Massachusetts, 02149

Private programs may not apply to certain primary or elective procedures that are not reimbursable by such coverage options. We encourage patients to contact their insurance carrier to ensure the services are covered and determine any out of pocket payments for the patient.

C. Hospital Locations providing medically necessary services as well as or in addition to Emergent, Urgent & Primary Care services covered by the Financial Assistance Policy:
The hospital's Financial Assistance Policy applies to Cambridge Health Alliance which includes three hospitals and the Physician Organization.

- The Cambridge Hospital
  1493Cambridge Street, Cambridge, MA 02139
  Monday thru Friday, 8:00 am to 5:00 pm

- Somerville Hospital
  230 Highland Avenue, Somerville, MA 02143
  Monday thru Friday, 8:00 am to 4:30 pm

- Whidden Memorial Hospital
  103 Garland Street, Everett, MA 02149
  Monday thru Friday, 8:00 am to 6:00 pm

Public Assistance Programs and Hospital Financial Assistance

A. General Overview of Health Coverage and Financial Assistance Programs
Hospital patients may be eligible for free or reduced cost of health care services through various state public assistance programs (including but not limited to MassHealth, the premium assistance payment program operated by the Health Connector, the Children's Medical Security Program, the Health Safety Net, and Medical Hardship). Such programs are intended to assist low-income patients taking into account each individual's ability to contribute to the cost of his or her care. For those individuals that are uninsured or underinsured, the hospital will, when requested, help them with applying for coverage through public assistance programs that may cover all or some of their unpaid hospital bills.

B. State Public Assistance Programs
The Hospital is available to assist patients in enrolling into state health coverage programs. These include MassHealth, the premium assistance payment program operated by the state's Health Connector, the Children's Medical Security Plan, the Health Safety Net, and Medical Hardship. For these programs, applicants can submit an application through an online website (which is centrally located on the state's Health Connector Website), a paper application, or over the phone with a customer service representative located at either MassHealth or the Connector. Individuals may also ask for assistance from hospital financial counselors (also called certified application counselors) with submitting the application either on the website or through a paper application.

B.1. Financial Assistance through the Health Safety Net
Through its participation in the Massachusetts Health Safety Net, the Hospital provides financial assistance to low-income uninsured and underinsured patients who are Massachusetts residents and who meet income qualifications. The Health Safety Net was created to more equitably distribute the cost of providing uncompensated care to low income uninsured and underinsured patients through free or discounted care across acute hospitals in Massachusetts. The Health Safety Net pooling of uncompensated care is accomplished through an assessment on each hospital to cover the cost of care for uninsured and underinsured patients with incomes under 300% the federal poverty level. It is the hospital's policy that all patients who receive financial assistance under the hospital's Financial Assistance Policy include the Health Safety Net services as part of the uncompensated care provided to low income patients.

Through its participation in the Health Safety Net, low-income patients receiving services at the Hospital may be eligible for financial assistance, including free or partially free care for Health Safety Net eligible services defined in 101 CMR 613:00.

(a) Health Safety Net - Primary

Uninsured patients who are Massachusetts residents with verified MassHealth MAGI household Income or Medical Hardship Family income, as described in 101 CMR 613.04(1), between 0-150% of the Federal Poverty Level (FPL) may be determined eligible for Health Safety Net Eligible Services.

The eligibility period and type of services for *Health Safety Net - Primary* is limited for patients eligible for enrollment in the Premium Assistance Payment Program operated by the Health Connector as described in 101 CMR 613.04(5)(a) and (b). Patients subject to the Student Health Program requirements of M.G.L. c. 15A, § 18 are not eligible for *Health Safety Net – Primary*.

(b) Health Safety Net – Secondary

Patients that are Massachusetts residents with primary health insurance and MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04(1), between 0 and 150% of the FPL may be determined eligible for Health Safety Net Eligible Services.

The eligibility period and type of services for *Health Safety Net - Secondary* is limited for patients eligible for enrollment in the Premium Assistance Payment Program operated by the Health Connector as described in 101 CMR 613.04(5)(a) and (b). Patients subject to the Student Health Program requirements of M.G.L. c. 15A, § 18 are not eligible for *Health Safety Net – Primary*.

(c) Health Safety Net - Partial Deductibles

Patients that qualify for *Health Safety Net Primary* or *Health Safety Net - Secondary* with MassHealth MAGI Household income or Medical Hardship Family Countable Income between 150.1% and 300% of the FPL may be subject to an annual deductible when all members of the Premium Billing Family Group (PBFG) have an income that is above 150.1% of the FPL. This group is defined in 130 CMR 501.0001.

If any member of the PBFG has an FPL below 150.1% there is no deductible for any member of the PBFG. The annual deductible is equal to the greater of:

the lowest cost Premium Assistance Payment Program Operated by the Health Connector premium, adjusted for the size of the PBFG proportionally to the MassHealth FPL income standards, as of the beginning of the calendar year; or

40% of the difference between the lowest MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04(1), in the applicant's Premium Billing Family Group (PBFG) and 200% of the FPL.

(d) Health Safety Net - Medical Hardship

A Massachusetts resident of any income may qualify for *Medical Hardship* through the Health Safety Net if allowable medical expenses have so depleted his or her countable income that he or she is unable to pay for health services. To qualify for *Medical Hardship*, the applicant's allowable medical expenses must exceed a specified percentage of the applicant's Countable Income defined in 101 CMR 613 as follows:

2025 MassHealth Income Standards and Federal Poverty Guidelines, Effective March 1, 2025

Family Size	MassHealth Income Standards		100% Federal Poverty Level		133% Federal Poverty Level		150% Federal Poverty Level		190% Federal Poverty Level	
	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly
1	$522	$6,264	$1,305	$15,660	$1,735	$20,820	$1,957	$23,484	$2,478	$29,736
2	$650	$7,800	$1,763	$21,156	$2,345	$28,140	$2,644	$31,728	$3,349	$40,188
3	$775	$9,300	$2,221	$26,652	$2,954	$35,448	$3,332	$39,984		
4	$891	$10,692	$2,680	$32,160	$3,564	$42,768	$4,019	$48,228		
5	$1,016	$12,192	$3,138	$37,656	$4,173	$50,076	$4,707	$56,484		
6	$1,141	$13,692	$3,596	$43,152	$4,783	$57,396	$5,394	$64,728		
7	$1,266	$15,192	$4,055	$48,660	$5,393	$64,716	$6,082	$72,984		
8	$1,383	$16,596	$4,513	$54,156	$6,002	$72,024	$6,769	$81,228		
For each additional person, add	$133	$1,596	$459	$5,508	$610	$7,320	$688	$8,256		

These figures are rounded and may not reflect the figures used in program determination. The Institutional Income Standard is $72.80.

Family Size	200% Federal Poverty Level		225% Federal Poverty Level		250% Federal Poverty Level		300% Federal Poverty Level		400% Federal Poverty Level	
	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly
1	$2,609	$31,308	$2,935	$35,220	$3,261	$39,132	$3,913	$46,956	$5,217	$62,604
2	$3,525	$42,300	$3,966	$47,592	$4,407	$52,884	$5,288	$63,456	$7,050	$84,600
3	$4,442	$53,304			$5,553	$66,636	$6,663	$79,956	$8,884	$106,608
4	$5,359	$64,308			$6,698	$80,376	$8,038	$96,456	$10,717	$128,604
5	$6,275	$75,300			$7,844	$94,128	$9,413	$112,956	$12,550	$150,600
6	$7,192	$86,304			$8,990	$107,880	$10,788	$129,456	$14,384	$172,608
7	$8,109	$97,308			$10,136	$121,632	$12,163	$145,956	$16,217	$194,604
8	$9,025	$108,300			$11,282	$135,384	$13,538	$162,456	$18,050	$216,600
For each additional person, add	$917	$11,004			$1,146	$13,752	$1,375	$16,500	$1,834	$22,008

These figures are rounded and may not reflect the figures used in program determination. The Institutional Income Standard is $72.80.

The applicant's required contribution is calculated as the specified percentage of Countable Income in 101 CMR 613.05(1)(b) based on the *Medical Hardship* Family's FPL multiplied by the actual Countable Income less bills not eligible for Health Safety Net payment, for which the applicant will remain responsible. Further requirements for *Medical Hardship* are specified 101 CMR 613.05.

B.2. Additional Financial Assistance

In addition to the Health Safety Net, the hospital provides financial assistance for those patients who meet its criteria as outlined below. This financial assistance is meant to supplement and not replace other coverage for services in order to ensure the financial assistance is provided when needed. The hospital will not deny financial assistance under its financial assistance policy based on the applicant's failure to provide information or documentation unless that information or documentation is described in and necessary for the determination of financial assistance through the application form.

1. Cambridge Health Alliance will offer a 25% discount off published charges to patients who do not qualify after being screened for MassHealth or Health Safety net eligibility using a MassHealth Benefit Request (MBR) and have no other insurance coverage that will provide reimbursement for the services. This discount will not apply to any coinsurance and/or deductibles.

2. The Hospital pursuant to an internal review of each patient's case, may offer a patient an additional discount on an unpaid bill as authorized by the hospital's Chief Financial Officer or his/her designee. This would exclude services identified as:
    i. "Fee for Services: i.e. Cosmetic Surgery, Plastic, Eye Glasses, Contacts, etc. Any item identified as Fee for Services.
    ii. Deductibles, co-pays, partial HSN.
    iii. In the event a patient refuses to be screened for any type of public assistance the patient will not qualify for additional discount on an unpaid bill. This discount would apply if paid within 30 days from the first statement. Any such review shall be part of an internal hospital financial assistance program that is applied on a uniform basis to patients, and which takes into consideration the patient's financial situation and the patient's inability to make a payment after reasonable collection actions. Any discount that is provided by the hospital is consistent with federal and state requirements, and is not based on an effort to induce a patient to receive services from the hospital or to generate business that is payable by federal or state programs.

3. MassHealth Spend Down/Health Safety Net Deductible
   In the event a patient applies for MassHealth/Health Safety Net and qualifies for a spend down, the patient is responsible for their self-pay balances with no discount, based on the regulations of the MassHealth and Health Safety Net programs.

4. For cases where the hospital is using the HIX Application, the hospital will assist the patient in completing the application for MassHealth, Health Safety Net, or other forms of financial assistance programs as they become part of the Affordable Care Act Program.

C. Notices & Application for Public Assistance Programs

C.1 Notices of Available Public Assistance Options

For those individuals who are uninsured or underinsured, the hospital will work with patients to assist them in applying for public assistance that may cover some or all of their unpaid hospital bills. In order to help uninsured and underinsured individuals find available and appropriate options, the hospital will provide all individuals with a general notice of the availability of public assistance during the patient's initial in-person registration at a hospital location for a service, in all billing invoices that are sent to a patient or guarantor, and when the provider is notified or through its own due diligence becomes aware of a change in the patient's eligibility status for public or private insurance coverage.

The hospital also posts general notices at service delivery areas with a registration or check-in area (including, but not limited to, inpatient, outpatient, emergency departments, and affiliated community health center locations), in Certified Application Counselor ("CAC") offices, and in general business office areas that are customarily used by Patients (e.g., admissions and registration areas, or patient financial services offices that are actively open to the public). The general notice will inform the patient about the availability of public assistance (including MassHealth, the premium assistance payment program operated by the Health Connector, the Children's Medical Security Program, the Health Safety Net and Medical Hardship) as well as the location(s) within the hospital and/or the phone numbers to call to schedule an appointment with a CAC. The goal of these general notices is to assist individuals in applying for coverage within one or more of these programs.

All notices are in English with the availability to obtain, upon request, 13 other languages through our Patient Relations Department. The notices are 18" x 24" laminated poster boards and are hung on the walls in all designated areas (See attached Exhibit).

C.2. Application for Public Assistance Programs

The Hospital is available to assist patients in enrolling into a state public assistance program. These include MassHealth, the premium assistance payment program operated by the state's Health Connector, and the Children's Medical Security Plan. Based on information provided by the patient, the hospital will also identify available coverage options though the Health Safety Net and Medical Hardship programs.

For programs other than Medical Hardship, applicants can submit an application through an online website (which is centrally located on the state's Health Connector Website), a paper application, or over the phone with a customer service representative located at either MassHealth or the Connector. Individuals may also ask for assistance from the hospital's certified application counselor with submitting the application on the website or through a paper application.

For Medical Hardship, the hospital will work with the patient to determine if a program like Medical Hardship would be appropriate and submit a Medical Hardship application to the Health Safety Net. It is the patient's obligation to provide all necessary information as requested by the

hospital in an appropriate timeframe to ensure that the hospital can submit a completed application. If the patient is able to provide all information in a timely manner, the hospital will endeavor to submit the total and completed application within five (5) business days of receiving all necessary and requested information. If the total and completed application is not submitted within five business days of receiving all necessary information, collection actions may not be taken against the patient with respect to bills eligible for Medical Hardship.

The hospital may also assist patients with enrolling in the Health Safety Net using a presumptive determination process, which provides a limited period of eligibility. This process is conducted by hospital and community health center staff, who, on the basis of self-attestation of financial information from the patient, will deem a patient as meeting the low income patient definition and will be covered for Health Safety Net services only. Coverage will begin on the date that the provider makes the determination through the end of the following month in which the presumptive determination is made. However, coverage may be terminated sooner if the patient submits a full application as described above.

C.3 Role of the Hospital Certified Application Counselor (CAC)

The hospital will help uninsured and underinsured individuals apply for health coverage through a public assistance program (including but not limited to MassHealth, the premium assistance payment program operated by the Health Connector, and the Children's Medical Security Program), and work with individuals to enroll them as appropriate. The hospital will also help patients that wish to apply for financial assistance, which includes coverage through the Health Safety Net and Medical Hardship.

The hospital will:

a) provide information about the full range of programs, including MassHealth, the premium assistance payment program operated by the Health Connector, the Children's Medical Security Program, Health Safety Net, and Medical Hardship;
b) help individuals complete a new application for coverage or submit a renewal for existing coverage;
c) work with the individual to obtain all required documentation;
d) submit applications or renewals (along with all required documentation);
e) interact, when applicable and as allowed under the current system limitations, with the Programs on the status of such applications and renewals;
f) help to facilitate enrollment of applicants or beneficiaries in Insurance Programs; and
g) offer and provide voter registration assistance.

The hospital will advise the patient of their obligation to provide the hospital and the applicable state agency with accurate and timely information regarding their full name, address, telephone number, date of birth, social security number (if available), current insurance coverage options (including home, motor vehicle, and other liability insurance) that can cover the cost of the care received, any other applicable financial resources, and citizenship and residency information. This information will be submitted to the state as part of the application for public program assistance to determine coverage for the services provided to the individual.

In the event an individual or guarantor is unable to provide the necessary information, the hospital may (at the individual's request) make reasonable efforts to obtain any additional information from other sources. Such efforts also include working with individuals, when requested by the individual, to determine when a bill for services should be sent to the individual to assist with meeting the one-time deductible. These efforts may occur when the individual is scheduling their services, during pre-registration, while the individual is admitted in the hospital, upon discharge, or for a reasonable time following discharge from the hospital. Information that the CAC obtains will be maintained in accordance with applicable federal and state privacy and security laws.

The hospital will also notify the patient during the application process of their responsibility to report to both the hospital and the state agency providing coverage of healthcare services to any third party that may be responsible for paying claims, including a home, auto, or other insurance liability policy. If the patient has submitted a third party claim or filed a lawsuit against a third party, the CAC will notify the patient of the requirement to notify the provider and the state program within 10 days of such actions. The patient will also be informed that they must repay the appropriate state agency the amount of the healthcare covered by the state program if there is a recovery on the claim, or assign rights to the state to allow it to recover its applicable amount.

When the individual contacts the hospital, the hospital will evaluate the information for that individual to determine qualification for a public assistance program or through the hospital financial assistance program. An individual who is enrolled in a public assistance program may qualify for certain benefits.