MAUI HEALTH SYSTEM
Community hospitals affiliated with KAISER PERMANENTE.

Policy Title: Financial Assistance Policy	Policy Number: 100-101-55
Owner Department: Finance	Effective Date: July 1, 2017
Custodian: Chief Financial Officer	Page: 1 of 12

1.0 Policy Statement

Maui Health System, a Kaiser Foundation Hospitals LLC (MHS), is committed to providing programs that facilitate access to care for vulnerable populations. This commitment includes providing financial assistance to qualified low income uninsured and underinsured patients when the ability to pay for services is a barrier to accessing emergency and medically necessary care.

2.0 Purpose

This policy describes the requirements for qualifying for and receiving financial assistance for emergency and medically necessary services through the MHS financial assistance policy (FAP). The requirements are compliant with Section 501(r) of the United States Internal Revenue Code addressing eligible services, how to obtain access, program eligibility criteria, the structure of financial assistance awards, the basis for calculating award amounts, and the allowable actions in the event of nonpayment of medical bills.

3.0 Scope

This policy applies to employees who are employed by the following entities:

3.1 Maui Health System Hospitals operated by Maui Health System, a Kaiser Foundation Hospitals LLC (MHS), which operates the following facilities:

3.1.1 Maui Memorial Medical Center

3.1.2 Kula Hospital

3.1.3 Lanai Community Hospital

4.0 Definitions

Refer to Appendix A – Glossary of Terms.

5.0 Provisions

MHS maintains a means-tested financial assistance program to mitigate financial barriers to receiving emergency and medically necessary care for eligible patients regardless of a patient's age, disability, gender, race, religious affiliation, social or immigrant status, sexual orientation, national origin, and whether the patient has health coverage.

5.1 Services that are Eligible and Not Eligible under the FAP.

5.1.1 Eligible Services. Financial assistance may be applied to emergency and medically necessary health care services, pharmacy services and products, and medical supplies provided by MHS at MHS facilities, or by providers that are subject to the policy. Financial assistance may be applied to services and products as described below:

5.1.1.1 Medically Necessary Services. Care, treatment, or services ordered or provided by a provider that is subject to the policy that are needed for the prevention, evaluation, diagnosis or treatment of a medical condition and are not mainly for the convenience of the patient or medical care provider**.**

5.1.1.2 Durable Medical Equipment (DME): Ordered by a provider that is subject to the policy and provided by MHS to a patient who meets the medical necessity criteria.

5.1.2 Non-Eligible Services. Financial assistance may not be applied to:

5.1.2.1 Services that are Not Considered Emergent or Medically Necessary. Including but not limited to:

5.1.2.1.1 Cosmetic surgery or services, including dermatology services that are primarily for improving a patient's appearance,

5.1.2.1.2 Retail medical supplies, and

5.1.2.1.3 Services related to third party liability, or workers' compensation cases.

5.1.2.2 Departments Staffed by Contracted Physicians and Providers. The FAP does not apply to the professional services received at departments within MHS facilities that are staffed exclusively by contracted physicians and providers that are not subject to the policy. Patients will receive a separate bill from those physicians and providers. Departments include:

5.1.2.2.1 Emergency Room,

5.1.2.2.2 Laboratory,

5.1.2.2.3 Anesthesiology,

5.1.2.2.4 Electrocardiogram (EKG),

5.1.2.2.5 Electroencephalogram (EEG),

5.1.2.2.6 Cardiopulmonary,

5.1.2.2.7 Nuclear Medicine, and

5.1.2.2.8 Radiology & Radiotherapy

5.1.2.3 Services Provided by Contracted Physicians and Providers. The only professional services to which the FAP applies are professional services provided by physicians and providers subject to the policy. Even upon referral from a physician or provider that is subject to the policy, all other services are ineligible for financial assistance. Patients will receive a separate bill from the physician or provider.

5.1.2.4 Services Provided Outside of MHS Facilities. The FAP applies only to services provided at MHS facilities. Services provided at non-MHS facilities, including medical offices, urgent care facilities and emergency departments, as well as home health, hospice, recuperative care, and custodial care services, are excluded.

5.2 Providers. The list of physicians and providers that are and are not subject to the FAP is available to the public, without charge, on the MHS financial assistance website at www.mauihealthsystem.org/fap.

5.3 Program Information Sources and How to Apply for Financial Assistance.

5.3.1 Program Information. Financial assistance information, including copies of the FAP, application forms, instructions, and plain language summaries (i.e., program brochures), is available to the public, without charge, in electronic format or hard copy. A patient can apply for financial assistance, during or following the care received from MHS, in several ways including in person, by telephone, or by paper application.

5.3.1.1 Download Program Information from the MHS Website. Electronic copies of program information are available on the financial assistance website at www.mauihealthsystem.org/fap.

5.3.1.2 Request Program Information Electronically. Electronic copies of program information are available by email upon request.

5.3.1.3 Obtain Program Information or Apply in Person. Program information is available at any MHS facility.

Maui Memorial Medical Center: Patient Access Services Department

Kula Hospital: Business Office

Lana'i Community Hospital: Business Office

5.3.1.4 Request Program Information or Apply by Telephone. Financial counselors are available by telephone to provide information, determine financial assistance eligibility, and assist a patient to apply for financial assistance. Financial counselors can be reached at 808-565-8456

5.3.1.5 Request Program Information or Apply by Mail. A patient can request program information and apply for financial assistance by submitting a complete financial assistance program application by mail. Information requests and applications can be mailed to:

Maui Health System - Lana'i Community Hospital

Attention: Financial Counseling Services

P.O. Box 630650

Lanai City, HI 96763

5.3.1.6 Personally Deliver Completed Application. Completed applications can be delivered in person to the Patient Access Services Department or Business Office in each MHS facility.

5.3.2 Applying for Financial Assistance. A patient can apply for financial assistance, during or following the care received from MHS, in several ways including in person, by telephone, or by paper application.

5.3.2.1 Screening Patients for Public and Private Program Eligibility. MHS provides financial counseling to patients applying for financial assistance to identify potential public and private health coverage programs that may help with health care access needs. A patient who is presumed eligible for any public or private health coverage programs is required to apply for those programs.

5.3.2.1.1 Patients with a financial status that exceeds the Medicaid income eligibility parameters will not be required to apply for Medicaid.

5.4 Information Needed to Apply for Financial Assistance. Complete personal, financial, and other information is required to verify a patient's financial status to determine eligibility for the financial assistance, as well as for public and private health coverage programs. Financial assistance may be denied due to incomplete information. Information can be provided in writing, in person, or over the telephone.

5.4.1 Verifying Financial Status. A patient's financial status is verified each time he or she applies for assistance. If a patient's financial status can be verified using external data sources, he or she may not be required to provide financial documentation.

5.4.2 Providing Financial and Other Information. If a patient's financial status cannot be verified using external data sources or the patient applies by mail, he or she may submit the information described in the financial assistance program application to verify his or her financial status.

5.4.2.1 Complete Information. Financial assistance eligibility is determined once all requested personal, financial, and other information is received.

5.4.2.2 Incomplete Information. A patient is notified in person, by mail, or by telephone if required information received is incomplete. The patient may submit the missing information within 30 days from the date the notice was mailed, the in-person conversation took place, or the telephone conversation occurred.

5.4.2.3 Requested Information Not Available. A patient who does not have the requested information described in the program application may contact MHS to discuss other available evidence that may demonstrate eligibility.

5.4.2.4 No Financial Information Available. A patient is required to provide basic financial information (e.g. income, if any, and source) and attest to its validity when (1) his or her financial status cannot be verified using external data sources, (2) requested financial information is not available and (3) no other evidence exists that may demonstrate eligibility. Basic financial information and attestation is required from the patient when he or she:

5.4.2.4.1 Is homeless, or

5.4.2.4.2 Has no income, does not receive a formal pay stub from his or her employer (excluding those who are self-employed), receives monetary gifts, or was not required to file a federal or state income tax return in the previous tax year.

5.4.3 Prequalified Patients. A patient is presumed to meet the program eligibility criteria and is not required to provide personal, financial and other information to verify financial status when he or she:

5.4.3.1 Was granted a prior financial assistance award within the last 30 days.

5.4.3.2 Is receiving inpatient mental / behavioral health services and has exhausted all insurance benefits.

5.4.4 Patient Cooperation. A patient is required to make a reasonable effort to provide all requested information. If all requested information is not provided, the circumstances are considered and may be considered when determining eligibility.

5.5 Presumptive Eligibility Determination. A patient who has not applied may be identified as eligible for financial assistance if his or her financial status can be validated using external data sources. If determined to be eligible, he or she may automatically be assigned an financial assistance award and sent a notification letter with an option to decline financial assistance. A patient may be identified without applying when he or she:

5.5.1 Is uninsured and (1) has a scheduled appointment for eligible services at an MHS facility, (2) has not indicated that he or she has health coverage, and (3) is presumed not eligible for Medicaid.

5.5.2 Has received care at an MHS facility and there are indications of financial hardship (e.g., past due or outstanding balances).

5.6 Program Eligibility Criteria. A patient applying for financial assistance may qualify based on means-tested, or high medical expense criteria.

5.6.1 Means-Testing Criteria. A patient is evaluated to determine if he or she meets means-testing eligibility criteria.

5.6.1.1 Eligibility Based on Income Level. A patient of a household where the household income is less than or equal to 250% of the Federal Poverty Guidelines (FPG) is eligible for financial assistance.

5.6.1.2 Household Income. Income requirements apply to the family members of the household. A family is a group of two or more persons related by birth, marriage, or adoption who live together. Family members can include spouses, qualified domestic partners, children, caretaker relatives, and the children of caretaker relatives that reside in the household.

5.6.2 High Medical Expense Criteria. A patient is evaluated to determine whether he or she meets high medical expense eligibility criteria.

5.6.2.1 Eligibility Based on High Medical Expenses. A patient of any household income level with incurred out-of-pocket medical and pharmacy expenses for eligible services over a 12-month period greater than or equal to 15% of annual household income is eligible for financial assistance.

5.6.2.1.1 MHS Out-of-Pocket Expenses. Medical and pharmacy expenses incurred at MHS facilities include copayments, deposits, coinsurance, and deductibles related to eligible services.

5.6.2.1.2 Non-MHS Out-of-Pocket Expenses. Medical, pharmacy, and dental expenses provided at non-MHS facilities, related to eligible services, and incurred by the patient (excluding any discounts or write offs) are included. The patient is required to provide documentation of the medical expenses for the services received from non-MHS facilities**.**

5.6.2.1.3 Health Plan Premiums. Out-of-pocket expenses do not include the cost associated with health insurance (i.e., premiums).

5.7 Denials and Appeals

5.7.1 Denials. A patient who applies for financial assistance and does not meet the eligibility criteria is informed either in writing or verbally that his or her request for financial assistance is denied.

5.7.2 How to Appeal a Financial Assistance Denial. A patient who believes that his or her application or information was not properly considered may appeal the decision. Instructions for completing the appeal process are included in the financial assistance denial letter. Appeals are reviewed by the designated MHS staff.

5.8 Award Structure. Financial assistance awards are applied to past due or outstanding balances only. The eligibility period for a financial assistance award is in effect for a limited period.

5.8.1 Basis of Award. The expenses paid by a financial assistance award are determined based on whether the patient has health care coverage or not.

5.8.1.1 Financial Assistance Eligible Patient without Health Care Coverage (Uninsured). An eligible uninsured patient receives a 100% discount on all eligible services.

5.8.1.2 Financial Assistance Eligible Patient with Health Care Coverage (Insured). An eligible insured patient receives 100% discount on that portion of a bill for all eligible services (1) for which he or she is personally responsible and (2) which is not paid by his or her insurance carrier. The patient is required to provide documentation, such as an Explanation of Benefits (EOB), to determine the portion of the bill not covered by insurance.

5.8.1.2.1 Payments Received from Insurance Carrier. An eligible insured patient is required to sign over to MHS any payments for services provided by MHS which the patient receives from his or her insurance carrier**.**

5.8.1.3 Reimbursements from Settlements. MHS pursues reimbursement from third party liability settlements, payers, or other legally responsible parties, as applicable.

5.8.2 Eligibility Period. The eligibility period for financial assistance awards commence from the date of approval, or the date services were provided or the date medications were dispensed. The eligibility period for a financial assistance award is in effect for a limited period.

5.8.2.1 Specific Period of Time.

5.8.2.1.1 Standard award eligibility period for eligible services: Up to 30 days

5.8.2.1.2 Extended award eligibility period for eligible services: Up to 90 days

5.8.2.2 Course of Treatment or Episode of Care. For a specific course of treatment and/or episode of care, as determined by a provider that is subject to the policy, for eligible services.

5.8.2.3 Request for Award Extension. A patient may request extension of an financial assistance award if he or she continues to meet the financial assistance eligibility requirements. Extension requests are evaluated on a case-by-case basis.

5.8.3 Award Revoked, Rescinded, or Amended. MHS may revoke, rescind, or amend a financial assistance award, in certain situations, at its discretion. Situations include:

5.8.3.1 Fraud, Theft, or Financial Changes. A case of fraud, misrepresentation, theft, changes in a patient's financial situation, or other circumstance which undermines the integrity of the financial assistance program.

5.8.3.2 Eligible for Public and Private Health Coverage Programs. A patient screened for public and private health coverage programs is presumed to be eligible but does not cooperate with the application process for those programs.

5.8.3.3 Other Payment Sources Identified. Health coverage or other payment sources identified after a patient receives a financial assistance award causes the charges for eligible services to be re-billed retroactively. If this occurs, the patient is not billed for that portion of a bill (1) for which he or she is personally responsible and (2) which is not paid by his or her health coverage or another payment source.

5.8.3.4 Change in Health Coverage. A patient who experiences a change in their health care coverage will be asked to reapply for the program.

5.9 Limitation on Charges. Charging financial assistance eligible patients, the full dollar amounts (i.e., gross charges) for eligible services rendered at a MHS hospital is prohibited. A patient who has received eligible services at a MHS hospital and is eligible for financial assistance, but has not received a financial assistance or has declined a financial assistance, is not charged more than the amounts generally billed (AGB) for those services.

5.9.1 Basis for Calculating Amounts Generally Billed (AGB). MHS determines AGB for any emergency or other medically necessary care using the prospective method by multiplying the gross charges for the care by the AGB rate. Information regarding the AGB rate and calculation is available on the MHS website at www.mauihealthsystem.org/fap.

5.10 Collection Actions.

5.10.1 Reasonable Notification Efforts. MHS or a collection agency acting on its behalf makes reasonable efforts to notify patients with past due or outstanding balances about the financial assistance program. Reasonable notification efforts include:

5.10.1.1 Providing one written notice within 120 days of first post-discharge statement informing account holder that financial assistance is available for those who qualify.

5.10.1.2 Providing a plain language summary of the FAP with the first hospital patient statement.

5.10.1.3 Attempting to notify the account holder verbally about the FAP and how to obtain assistance through the financial assistance application process.

5.10.2 Prohibited Extraordinary Collection Actions. MHS does not perform, allow, or allow collection agencies to perform the following extraordinary collection actions under any circumstance:

5.10.2.1 Report adverse information to consumer credit reporting agencies or credit bureaus.

5.10.2.2 Defer, deny, or require payment, due to an account holder's nonpayment of a previous balance, before providing emergency or medically necessary care.

5.10.2.3 Sell an account holder's debt to a third party.

5.10.2.4 Legal or judicial actions, such as:

5.10.2.4.1 Garnishment of wages.

5.10.2.4.2 Attaching an individual's bank account or any other personal property.

5.10.2.4.3 Liens on residences.

5.10.2.4.4 Foreclosure on property or seizure of accounts.

5.10.2.4.5 Request warrants for arrest.

5.10.2.4.6 Request writs of body attachment.

6.0 References / Appendices

6.1 Appendix A – Glossary of Policy Terms

6.2 Laws, Regulations, and Resources

6.2.1 Patient Protection and Affordable Care Act, Public Law 111-148 (124 Stat. 119 (2010))

6.2.2 Federal Register and the Annual Federal Poverty Guidelines

6.2.3 Internal Revenue Service Publication, 2014 Instructions for Schedule H (Form 990)

6.2.4 Internal Revenue Service Notice 2010-39

6.2.5 Internal Revenue Service Code, 26 CFR Parts 1, 53, and 602, RIN 1545-BK57; RIN 1545-BL30; RIN 1545-BL58 – Additional Requirements for Charitable Hospitals

6.2.6 Catholic Health Association of the United States – A Guide for Planning & Reporting Community Benefit, 2012 Edition

Appendix A

Glossary of Terms

Charity Care is medical or health services, products, or medication provided at reduced or no cost to patients who do not have the ability to pay and/or are not covered by health care insurance.

Durable Medical Equipment (DME) includes, but is not limited to, standard canes, crutches, nebulizers, intended benefitted supplies, over the door traction units for use in the home, wheelchairs, walkers, hospital beds, and oxygen for use in the home as specified by DME criteria. DME does not include orthotics, prosthetics (e.g., dynamic splints/orthoses, and artificial larynx and supplies) and over-the-counter supplies and soft goods (e.g., urological supplies and wound supplies).

Eligible Patient is an individual who meets the eligibility criteria described in this policy, whether he or she is (1) uninsured; (2) receives coverage through a public program (e.g., Medicare, Medicaid, or subsidized health care coverage purchased through a health information exchange); (3) receives coverage through a health plan or commercial insurance.

External Data Sources are third-party vendors, credit reporting agencies, etc., that provide financial status information used by MHS to validate or confirm a patient's financial status when assessing eligibility for the financial assistance program.

Federal Poverty Guidelines (FPG) establishes the levels of annual income for poverty as determined by the United States Department of Health and Human Services and are updated annually in the Federal Register.

Financial Counseling is the process used to assist patients to explore the various financing and health coverage options available to pay for services rendered in MHS facilities. Patients who may seek financial counseling include, but are not limited to, self-pay, uninsured, underinsured, and those who have expressed an inability to pay the full patient liability.

Homeless describes the status of a person who resides in one of the places or is in a situation described below:

- In places not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings (on the street); or
- In an emergency shelter; or
- In transitional or supportive housing for homeless persons who originally came from the streets or emergency shelters.
- In any of the above places but is spending a short time (up to 30 consecutive days) in a hospital or other institution.
- Is being evicted within a week from a private dwelling unit or is fleeing a domestic violence situation with no subsequent residence identified and the person lacks the resources and support networks needed to obtain housing.
- Is being discharged within a week from an institution, such as a mental health or substance abuse treatment facility in which the person has been a resident for more than 30 consecutive days and no subsequent residence has been identified and the person lacks the financial resources and social support networks needed to obtain housing.

MHS Facilities include any physical premises, including the interior and exterior of a building, operated by MHS in the conduct of MHS business functions, including patient care delivery (e.g., a building, or a MHS floor, unit, or other interior or exterior area of a non-MHS building).

Means-Tested is the method by which external data sources or information provided by the patient are used to determine eligibility for a public coverage program or financial assistance based on whether the individual's income is greater than a specified percentage of the Federal Poverty Guidelines.

Financial Assistance provides monetary awards to pay medical costs to eligible patients who are unable to pay for all or part of medically necessary services, and who have exhausted public and private payer sources. Individuals are required to meet program criteria for assistance to pay some or all the cost of care.

Medical Supplies refer to non-reusable medical materials such as splints, slings, wound dressings, and bandages that are applied by a licensed health care provider while providing a medically necessary service, and excluding those materials purchased or obtained by a patient from another source.

Safety Net refers to a system of nonprofit organizations and/or government agencies that provide direct medical care services to the uninsured in a community setting such as a public hospital, community clinic, church, homeless shelter, mobile health unit, school, etc.

Underinsured is an individual who, despite having health care coverage, finds that the obligation to pay insurance premiums, copayments, coinsurance, and deductibles is such a significant financial burden that he or she delays or does not receive necessary health care services due to the out-of-pocket costs.

Uninsured is an individual who does not have health care insurance or federal- or state-sponsored financial assistance to help pay for the health care services.

Vulnerable Populations include demographic groups whose health and well-being are considered to be more at-risk than the general population due to socioeconomic status, illness, ethnicity, age, or other disabling factors.

Writ(s) of Body Attachment is a process initiated by a court directing the authorities to bring a person found to be in civil contempt before the court, like an arrest warrant.