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1.0 Policy Statement

Maui Health (MH) 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 Financial Assistance program (FAP). The requirements are compliant with Section 501(r) of the United States Internal Revenue Code and applicable state regulations addressing eligible services, how to obtain access, program eligibility criteria, the structure of FAP awards, the basis for calculating award amounts, and the allowable actions in the event of nonpayment of medical bills.

3.0 Scope/Coverage

3.1 The provisions of this policy apply to the following persons:

3.1.1 All employees of Maui Health System, a Kaiser Foundation Hospitals LLC (MHS);

- a. Maui Memorial Medical Center (MMMC)
- b. Kula Hospital (Kula)
- c. Lanai Community Hospital (LCH)
- d. Maui Memorial Outpatient Clinic
- e. Kula Outpatient Clinic

3.1.2 All practitioners at MHS, including but not limited to, members of the Medical Staffs and Advanced Practice Providers;

3.1.3 All contingent workers, contractors, vendors, volunteers, students, or other persons providing paid or unpaid services to a MHS entity.

4.0 Definitions

See Appendix A- Glossary of Terms



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5.0 Provisions/ Procedures. MHS shall ensure that this policy is adhered to by following all of the steps set forth in this policy. MH maintains a means-tested FAP 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 or immigration status, sexual orientation, national origin, and whether the patient has health coverage.

5.1 Services That Are Eligible and Not Eligible Under the FAP Policy

5.1.1 Eligible Services. FAP may be applied to certain (1) medically necessary health care services, including emergency care; (2) pharmacy services and products; and (3) medical supplies provided at MH facilities (e.g., hospitals, hospital-affiliated clinics, medical centers, and medical office buildings), at MH outpatient, mail order and specialty pharmacies, or by Provider that is subject to the policy, as described below:

- a. **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.
- b. **Durable Medical Equipment (DME).** Applicable DME is limited to equipment regularly available from MH facilities and supplied by MH to a patient who meets the medical necessity criteria. DME must be ordered by a Provider that is subject to the policy in accordance with DME guidelines.
- c. **Medicaid Denied Services.** Medical services, prescriptions, pharmacy supplies, and DME that are not covered by the state Medicaid program but determined to be medically necessary and ordered by a Provider that is subject to the policy (e.g., newborn circumcision, hernia services, pharmaceutical compounds, drugs to treat symptoms, etc.).



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- d. **Health Education Classes.** Available classes scheduled and provided by KP that are recommended by a Provider that is subject to the policy as part of the patient's care plan.
- e. **Services Available on an Exception Basis.** In certain exceptional situations, FAP may be applied to select services and supplies needed to facilitate inpatient discharge from a hospital that meet the High Medical Expense Eligibility criteria explained below, see section 5.6.2. If the patient meets the criteria, covered services may include Skilled Nursing, Intermediate Care and Custodial services provided at a non-KP facility. Supplies may include DME prescribed or ordered by a Provider that is subject to the policy and supplied by a contracted/vendor as described below.
- f. **Skilled Nursing Services, Intermediate Care and Custodial Services.** Provided by a contracted KP facility to a patient with a prescribed medical need to facilitate inpatient discharge from a hospital.
- g. **Durable Medical Equipment (DME).** Vendor-supplied DME ordered by a Provider that is subject to the policy in accordance with the DME guidelines and supplied by a contracted vendor through the MH DME Department. SOX key control activity standards

5.1.2 **Non-Eligible Services.** FAP may not be applied to:

- a. **Services that are Not Considered Emergent or Medically Necessary as Determined by a Provider that is subject to the policy.** The following is a non-exhaustive list of examples of services that are non-emergent or not medically necessary:
 - (1) Cosmetic surgery or services, including dermatology services that are primarily for the purpose of improving a patient's appearance.
 - (2) Infertility treatments and related services including diagnostics.
 - (3) Retail medical supplies.



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- (4) Alternative therapies, including acupuncture, chiropractic, and massage services.
- (5) Injections and devices to treat sexual dysfunction.
- (6) Surrogacy services.
- (7) Services related to third party liability, personal insurance protection or workers' compensation cases.

b. Prescriptions and Pharmacy Supplies that are Not Considered Emergent or Medically Necessary.

Prescriptions and pharmacy supplies not considered emergent or medically necessary include, but are not limited to:

- (1) Drugs that have not been approved by the Pharmacy.
- (2) Over-the-counter drugs and supplies not prescribed or ordered by a Provider that is subject to the policy.
- (3) Over-the-counter drugs and supplies that are not regularly available in the MHS pharmacy and must be specially ordered.
- (4) Prescriptions related to third party liability, personal insurance protection or workers' compensation cases.
- (5) Specifically excluded drugs (e.g., fertility, cosmetic, sexual dysfunction).

c. 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 invoice from those physicians and providers. Departments include, but are not limited to:

- (1) Emergency Room;
- (2) Laboratory;
- (3) Anesthesiology;
- (4) Respiratory services;
- (5) Heart, Brain & Vascular (HBV) services;



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(6) Radiology services

- d. **Services Provided Outside of MH Facilities.** The FAP policy applies only to services provided at MH facilities, or by a provider that is subject to the policy.

5.2 **Providers.** FAP is applied only to eligible services delivered by medical care providers to whom the FAP policy applies.

5.3 **Program Information Sources and How to Apply for FAP.**

Additional information about the FAP program and how to apply is summarized here, [Financial assistance | Maui Health](http://www.mauihealth.org/patients-and-visitors/billing-information/financial-assistance/), www.mauihealth.org/patients-and-visitors/billing-information/financial-assistance/.

5.3.1 **Program Information Sources.** Copies of the FAP policy, application forms, instructions, and plain language summaries (i.e., policy summaries or program brochures) are available to the public, without charge, from MH's website, by email, in person, or by US postal mail.

5.3.2 **Applying for FAP.** To apply for the FAP program, a patient is required to demonstrate an immediate need caused by a bill for an outstanding balance for MH services, a scheduled appointment with MH, or a pharmacy prescription ordered by a provider that is subject to the policy for eligible services as described above. A patient can apply for the FAP program in several ways, including online, in person or by paper application.

a. **MH FAP Program.** Patients are required to apply for the MH FAP program when receiving services from MH even if they are eligible for KP Medical Financial Assistance.

b. **Screening Patients for Public and Private Program Eligibility.** MH encourages all individuals to obtain health insurance coverage for ensuring access to healthcare services, for overall personal health, and for the protection of patient assets. MH will assist uninsured patients or their guarantors in identifying and applying for available assistance programs including Medicaid and coverage available on the Health Benefit Exchange. A patient who is presumed eligible for Medicaid or coverage



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available on the Health Benefit Exchange may be required to apply for those programs. 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 FAP.** Complete personal, financial, and other information is required to verify a patient's financial status to determine eligibility for the FAP program, as well as eligibility for Medicaid and subsidized coverage available on the Health Benefit Exchange. A patient's financial status is verified each time the patient applies for assistance.
- 5.4.1 **Providing Financial Information.** Patients are required to include household size and household income information with their FAP application, however, submitting financial documentation to allow verification of financial status is optional unless specifically requested by KP.
- a. **Verifying Financial Status without Financial Documentation.** If financial documentation is not included with the FAP application, a patient's financial status will be verified using external data sources. If a patient's financial status cannot be verified using external data sources, the patient may be asked to submit the financial documentation described in the FAP program application to allow verification of their financial status.
- b. **Verifying Financial Status with Financial Documentation.** If financial documentation is included with the FAP application, eligibility will be based on the information provided.
- 5.4.2 **Providing Complete Information.** FAP program eligibility is determined once all requested personal, financial, and other information is received.
- 5.4.3 **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 either: the date the notice was mailed, the in-person conversation took place, or the telephone



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conversation occurred. FAP may be denied due to incomplete information.

5.4.4 Requested Information Not Available. A patient who does not have the requested information described in the program application may contact MH to discuss other available documentation to demonstrate eligibility.

5.4.5 No Financial Information Available. A patient is required to provide basic financial information (i.e., income, if any, and source) at a minimum and attest to its validity when: (1) their financial status cannot be verified using external data sources; (2) requested financial information is not available; and (3) no other documentation exists that may demonstrate eligibility. Basic financial information and attestation is required from the patient if any of the following apply:

- a. The patient is homeless or recipient of care from a homeless clinic.
- b. The patient has no income, does not receive a formal pay stub from their 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.
- c. The patient has been affected by a well-known national or regional disaster or public health emergency (Refer to Section 5.11 below).

5.4.6 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 may be considered when determining eligibility.

5.5 Presumptive Eligibility Determination. Financial assistance may be approved in the absence of a completed application in situations where the patient has an outstanding balance, has not responded to MH outreach attempts and has not applied but other available information substantiates a financial hardship. If determined to be eligible, the patient is not required to provide personal, financial, or other information to verify financial status



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and will automatically be assigned an FAP award. The reason and supporting information for presumptive eligibility determination will be documented in the patient's account and additional patient notes may be included. A patient is presumed to be eligible and document requirements are waived if the patient has been prequalified or there are indications of financial hardship.

5.5.1 Prequalified. Situations where there is evidence that a patient is enrolled in or is determined by the financial screening process to potentially qualify for the public and private assistance programs noted below is presumed eligible (i.e., prequalified) for the FAP program. The patient is considered prequalified if the patient meets any of the following criteria:

- a. Is enrolled in a Community FAP (CFAP) program to which patients have been referred and prequalified through: (1) federal, state, or local government, (2) a partnering community-based organization, or (3) at a MH sponsored community health event.
- b. Is enrolled in a MH Community Benefit program designed to support access to care for low-income patients and prequalified by designated MH personnel.
- c. Is enrolled in or is presumed to be eligible for a credible means-tested health coverage program (e.g., Medicaid, Medicare Low Income Subsidy Program, Subsidized coverage available on the Health Benefit Exchange.).
- d. Is enrolled in a credible means-tested public assistance program (e.g., Women, Infants and Children programs, Supplemental Nutrition and Assistance programs, Low-income household energy assistance programs, free or reduced cost lunch programs).
- e. Resides in low-income or subsidized housing.
- f. Was granted a prior FAP award that began within the last 30 days.

5.5.2 Indications of Financial Hardship. A patient who has received care at an MH facility and for whom there are indications of financial hardship (e.g., past due outstanding



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balances or inability to pay) may be screened by MH for program eligibility and financial hardship using external data sources. If eligible, the patient will receive an FAP award for eligible outstanding balances only.

- a. **Eligibility Determination by MH.** MH may screen patients for program eligibility before their outstanding balances are placed with a debt collection agency.
 - (1) **Outstanding Self-pay Balances.** MH will screen patients that have been identified for placement with a debt collection agency for program eligibility based on means-testing criteria. See section 5.6.1 below.
 - (2) **Indications of Financial Hardship.** Financial information for some patients with outstanding balances may not be available to determine eligibility, but other indications of financial hardship made known to MH may lead to the determination of low income. Eligible outstanding balances will be applied to the FAP program and will not be subject to further collection actions. Indications of financial hardship may include, but are not limited to:
 - a) The patient is a non-U.S. citizen without sponsorship, social security number, tax records, or valid billing addresses; has not communicated with MH about their account; and reasonable collection efforts demonstrate the patient does not have financial or asset resources in their country of origin.
 - b) The patient has outstanding balances for previously provided MH services and has since been incarcerated in prison for an extended period of time; is not married; there are no indications of income; and MH has been unable to contact the patient.
 - c) Patient is deceased with no estate/assets or record of a relative responsible for debts.



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d) Patient is deceased, and the probate or estate shows insolvency.

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

5.6.1 Means-testing Criteria. A patient is evaluated to determine if the patient meets means-testing eligibility criteria.

- a. **Eligibility Based on Income Level.** A patient with a gross household income less than or equal to MH's means-testing criteria as a percentage of the Federal Poverty Guidelines (FPG) is eligible for financial assistance. Assets are not considered in the means-test.
- b. **Household Income.** Income requirements apply to the members of the household. A household means a single individual or group of two or more persons related by birth, marriage, or adoption who live together. Household members may include spouses, qualified domestic partners, children, caretaker relatives, the children of caretaker relatives, and other individuals for whom the single individual, spouse, domestic partner, or parent is financially responsible who reside in the household.

5.6.2 High Medical Expense Criteria. A patient is evaluated to determine if the patient meets high medical expense eligibility criteria.

- a. **Eligibility Based on High Medical Expenses.** A patient of any gross household income level with incurred out-of-pocket medical and pharmacy expenses for eligible services over the 12-month period prior to application greater than or equal to 10% of annual household income is eligible for financial assistance.
 - (1) **MH Out-of-Pocket Expenses.** Medical and pharmacy expenses incurred at MH facilities include copayments, deposits, coinsurance, and deductibles related to eligible services.



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(2) **Non-MH Out-of-Pocket Expenses.** Medical, pharmacy, and dental expenses provided at non-MH facilities related to eligible medically necessary 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-KP facilities.

a) If the non-MH provider where charges are incurred offers a Financial Assistance program for which the patient may be eligible, the patients must apply before charges will be considered an eligible medical expense.

(3) **Health Plan Premiums.** Out-of-pocket expenses do not include the cost associated with health care coverage (i.e., dues or premiums).

5.7 Denials and Appeals

5.7.1 **Denials.** A patient who applies for the FAP program and does not meet the eligibility criteria is informed in writing that their request for FAP is denied.

5.7.2 **How to Appeal an FAP Denial.** Patients that have been denied FAP or have been approved and believe they qualify for a higher FAP award may appeal the decision. Patients are encouraged to appeal if they: (1) have not previously submitted financial documentation, or (2) their household income has changed. Instructions for completing the appeal process are included in the FAP denial and approval letters as well as the FAP website. Appeals are reviewed by the designated MH staff. Patients are informed in writing of the outcome of their appeal. All appeal decisions are final.

5.8 **Award Structure.** FAP awards are applied to eligible past due or outstanding balances, balances placed with a debt collection agency, and pending charges. FAP awards may also include an



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eligibility period for any required follow-up services as determined by a provider that is subject to the policy.

5.8.1 **Basis of Award.** The patient cost paid by the FAP program is determined based on whether the patient has health care coverage and the patient's household income.

a. **FAP-Eligible Patient without Health Care Coverage (Uninsured).** An eligible uninsured patient receives a discount on the patient cost of all eligible services.

b. **FAP-Eligible Patient with Health Care Coverage (Insured).** An eligible insured patient receives a discount on patient cost for all eligible services which (1) the patient is personally responsible for, and (2) is not paid by their 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. An eligible insured patient is required to file an appeal with their insurance carrier for any denied claims. Eligible insured patients are required to provide documentation of their insurance carrier's denial of appeal.

(1) **Payments Received from Insurance Carrier.** An eligible insured patient is required to sign over to MH any payments for services provided by MH which the patient receives from that patient's insurance carrier.

c. **Discount Schedule.** The amounts that MH charges a patient who qualifies for financial assistance is based on the type of eligibility criteria used to qualify the patient for the program. Information about available discounts under the policy are summarized above, paragraph (a).

(1) **Presumptive Eligibility Determination – Prequalified.** A patient who is prequalified (as summarized in section 5.5.1) for FAP eligibility will receive a 100% FAP discount on the patient cost or charges for services provided for which the patient is responsible.



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(2) **Presumptive Eligibility Determination by MH – Outstanding Self-pay Balances.** A patient that meets means-testing criteria will receive a sliding scale FAP discount on the patient cost or portion of charges for services provided for which the patient is responsible.

(3) **Presumptive Eligibility Determination by MH – Indications of Financial Hardship.** A patient that meets indications of financial hardship criteria will receive a 100% FAP discount on the patient cost or portion of charges for services provided for which the patient is responsible.

(4) **Patient Meets Means-testing Criteria.** A patient who meets means-testing criteria will receive a sliding scale FAP discount on the patient cost or portion of charges for services provided for which the patient is responsible.

(5) **Patient Meets High Medical Expense Criteria.** A patient who meets high-medical expense criteria will receive a 100% FAP discount on the patient cost or charges for services provided for which the patient is responsible.

d. **Reimbursements from Settlements.** MH pursues reimbursement from third party liability / personal insurance protection settlements, payers, or other legally responsible parties, as applicable.

5.8.2 **Award Eligibility Period.** The eligibility period for follow-up services commences from the date of approval, or the date services were provided, or the date medications were dispensed. The duration of the eligibility period is a limited time only and is determined at the discretion of MH in various ways, including:

a. **Specific Period of Time.** A maximum of 365 days for eligible follow-up services and outstanding patient cost balances identified prior to bad debt referral.



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- b. **Skilled Nursing, Custodial Services and Intermediate Care.** A maximum of 30 days for services provided at an MH facility.
- c. **Durable Medical Equipment.** A maximum of 180 days for vendor-supplied medical equipment.
- d. **Course of Treatment or Episode of Care.** A maximum of 180 days for a course of treatment and/or episode of care as determined by a provider that is subject to the policy.
- e. **Re-applying for Financial Assistance.** Beginning thirty (30) days before the expiration date of the existing award and anytime thereafter, a patient may reapply for the program.

5.8.3 **Award Revoked, Rescinded, or Amended.** MH may revoke, rescind, or amend an FAP award, in certain situations, at its discretion. Situations include:

- a. **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 FAP program.
- b. **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.
- c. **Other Payment Sources Identified.** Health coverage or other payment sources identified after a patient receives an FAP 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 the patient is personally responsible and (2) which is not paid by their health coverage or other payment source.
- d. **Change in Health Coverage.** A patient who experiences a change in health care coverage will be asked to reapply to the FAP program.



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- e. **Change in Household Income.** A patient who experiences a change in household income will be asked to reapply to the FAP program.

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

5.9.1 **Amounts Generally Billed (AGB).** MH 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 AGB rate and calculation is available on the MH website at www.mauhealth.org/fap.

5.10 **Collection Actions**

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

- a. Providing one written notice within 120 days of first post-discharge statement informing account holder that FAP is available for those who qualify.
- b. Providing written notice with the list of extraordinary collection actions (ECAs) that MH or a debt collection agency intends to initiate for payment of patient cost balance, and the deadline for such actions, which is no earlier than 30 days from written notice.
- c. Providing a plain language summary of the FAP policy with the first hospital patient statement.
- d. Attempting to notify the account holder verbally about the FAP policy and how to obtain assistance through the FAP application process.



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- e. Determining program eligibility upon request, before past due or outstanding patient balances are transferred to a debt collection agency.

5.10.2 Extraordinary Collection Actions Suspended. MH does not conduct or permit debt collection agencies to conduct on its behalf, extraordinary collection actions (ECAs) against a patient if the patient:

- a. Has an active FAP award, or
- b. Has initiated an FAP application after ECAs have begun. ECAs are suspended until a final eligibility determination is made.

5.10.3 Allowable Extraordinary Collection Actions.

- a. **Final Determination of Reasonable Efforts.** Prior to initiating any ECAs, the regional Revenue Cycle Patient Financial Services Leader ensures the following:
 - (1) Completion of reasonable efforts to notify the patient of the FAP program, and
 - (2) The patient has been provided at least 240 days from the first billing statement to apply for FAP.
- b. **Reporting to Consumer Credit Agencies or Credit Bureaus.** MH or a debt collection agency acting on its behalf may report adverse information to consumer credit reporting agencies or credit bureaus.
 - (1) **Judicial or Civil Actions.** Prior to pursuing any judicial or civil actions, MH validates the patient's financial status using external data sources to determine if the patient is eligible for the FAP program.
 - (2) **Eligible for FAP.** No additional actions are pursued against patients who are eligible for the FAP program. Accounts that qualify for FAP are cancelled and returned on a retrospective basis.
 - (3) **Not Eligible for FAP.** In very limited cases, the following actions may be conducted with prior



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approval from the regional Chief Financial Officer or Controller:

- a) Garnishment of wages
- b) **Lawsuits/civil actions.** Legal action is not pursued against an individual who is unemployed and without other significant income.
- c) Liens on residences.

5.10.4 Prohibited Extraordinary Collection Actions. MH does not perform, allow, or allow debt collection agencies to perform, the following actions under any circumstance:

- a. Defer or deny care due to an account holder's nonpayment of a previous balance or require payment before providing emergency or medically necessary care.
- b. Sell an account holder's debt to a third party.
- c. Foreclosure on property or seizure of accounts.
- d. Request warrants for arrest.
- e. Request writs of body attachment.

5.11 Disaster and Public Health Emergency Response. MH may temporarily modify its FAP program eligibility criteria and application processes to enhance the assistance available to communities and patients affected by a well-known event that has been qualified as a disaster or public health emergency by the state or federal government.

5.11.1 Potential Eligibility Modifications. Temporary changes to FAP eligibility criteria may include:

- a. Suspending eligibility restrictions.
- b. Increasing the means-testing criteria threshold.
- c. Decreasing the high medical expense criteria threshold.

5.11.2 Potential Application Process Modifications.

Temporary changes to the FAP application process may include:



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- a. Allowing patients to provide basic financial information (i.e., income, if any, and source) and attest to its validity when (1) their financial status cannot be verified using external data sources, (2) requested financial information is not available due to the event, and (3) no other evidence exists that may demonstrate eligibility.
- b. Taking into consideration the impact of future loss of wages/ employment due to the event when determining household income.

5.11.3 Information Available to the Public. Information describing temporary FAP program changes is made available to the public on the FAP program web page and at KP facilities in the affected areas.

6.0 References/Appendices

6.1 References

- 6.1.1 [Patient Protection and Affordable Care Act, Public Law 111-148 \(124 Stat. 119 \(2010\)\)](#)
- 6.1.2 [Federal Register and the Annual Federal Poverty Guidelines](#)
- 6.1.3 [Internal Revenue Service Publication, 2014 Instructions for Schedule H \(Form 990\)](#)
- 6.1.4 Internal Revenue Service Notice 2010-39
- 6.1.5 [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](#)
- 6.1.6 California Hospital Association – Hospital Financial Assistance Policies & Community Benefit Laws, 2015 Edition
- 6.1.7 [Catholic Health Association of the United States – A Guide for Planning & Reporting Community Benefit, 2012 Edition](#)
- 6.1.8 Provider List. A provider list is available at the MH website.

6.2 Appendices

- 6.2.1 Appendix A- Glossary of Terms

6.3 Attachments

- 6.3.1 Addendum for Maui Health

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7.0 Approval

This policy was approved by the following representative(s) of Maui Health System.

Contact Person:	Nanea Wasserman, Patient Access Services Manager	
Approved by:	Deb Cartwright, VP CFO	Date: 2/13/2025



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Appendix A — Glossary of Terms

Community FAP (CFAP) — Planned medical financial assistance programs that collaborate with community based and safety net organizations to provide access to medically necessary care to low income uninsured and underinsured patients at KP facilities.

Debt Collection Agency — A person or organization that, by direct or indirect action, conducts or practices collections or attempts to collect a debt owed, or alleged to be owed, to a creditor or debt buyer.

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 — An individual who meets the eligibility criteria described in this policy, whether the patient is (1) uninsured; (2) receives coverage through a public program (e.g., Medicare, Medicaid, or subsidized health care coverage purchased through a health insurance exchange); (3) is insured by a health plan other than KFHP; or (4) is covered by KFHP.

External Data Sources — Third-party vendors used to review a patient's personal information to assess financial need by utilizing a model based on public record databases which assesses each patient based on the same standards to calculate a patient's financial capacity score.

Federal Poverty Guidelines (FPG) — 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 — The process used to assist patients to explore the various financing and health coverage options available to pay for services rendered in KP 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 — A status descriptor for the living situation of a person, as described below:



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- In places not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings (on the street).
- In an emergency shelter.
- 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.

KP — Includes Kaiser Foundation Hospitals and affiliated-hospital clinics, Kaiser Foundation Health Plans, Permanente Medical Groups, and their respective subsidiaries, except Kaiser Permanente Insurance Company (KPIC).

MH Facilities — Any physical premises, including the interior and exterior of a building, owned, or leased by MH in the conduct of MH business functions, including patient care delivery (e.g., a building, or a MH floor, unit, or other interior or exterior area of a non-MH building).

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

Financial Assistance Program (FAP) — A program that provides awards to pay medical costs for eligible patients who are unable to pay for all or part of their medically necessary services, products, or medication, and who have exhausted public and private payer sources. Individuals are required to meet program criteria for assistance to pay some or all the patient cost of care.



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Medical Supplies — 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.

Patient Cost — The portion of charges billed to a patient for care received at KP facilities (e.g., hospitals, hospital-affiliated clinics, medical centers, medical office buildings and outpatient pharmacies) that are not reimbursed by insurance or a publicly funded health care program.

Pharmacy Waiver — Provides financial assistance to low-income KP Senior Advantage Medicare Part D members who are unable to afford their cost share for outpatient prescription drugs covered under Medicare Part D.

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

Underinsured — 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 the patient delays or does not receive necessary health care services due to the out-of-pocket costs.

Uninsured — 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** — 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 — A process initiated by a court directing the authorities to bring a person found to be in civil contempt before the court, similar to an arrest warrant.



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ADDENDUM: Maui Health

ADDENDUM EFFECTIVE DATE: February 2025

- I. **MH Facilities.** This policy applies to all MH facilities (e.g., hospitals, hospital-affiliated clinics, and medical office buildings). Maui Health Hospitals include:
- Maui Memorial Medical Center
 - Kula Hospital
 - Lanai Community Hospital
- II. **Providers Subject to and Not Subject to the FAP Policy.** The list of providers in Kaiser Foundation Hospitals that are and are not subject to the FAP policy is available to the general public, without charge, on the Maui Health website at: www.mauihealth.org/patients-and-visitors/billing-information/financial-assistance/
- III. **Program Information and Applying for FAP.** FAP program information, including copies of the FAP policy, application forms, instructions, and plain language summaries (e.g., program brochures), is available to the general public, without charge, in electronic format or hard copy. A patient can apply for the FAP program, during or following the care received from MH, in several ways including in person, by telephone, or by paper application. (Refer to sections 5.3 and 5.4 of the policy.)
- a. **Download Program Information from the MH Website.** Electronic copies of program information are available on the FAP website at www.mauihealth.org/patients-and-visitors/billing-information/financial-assistance/.
 - b. **Request Program Information Electronically.** Electronic copies of program information are available by email upon request.
 - c. **Obtain Program Information or Apply in Person.** Program information is available at Patient Access Services Department in the Maui Health Hospitals listed in Section I, Maui Health Hospitals. Financial Counselors are also available at MH hospitals to provide program information and to quickly determine FAP eligibility. Counselors are available at the Patient Access Services Department in each of the following MH facilities:
 - Maui Memorial Medical Center
 - 221 Mahalani Street



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Wailuku, HI 96793
Fax: 1-808-242-2471

Kula Hospital
100 Keokea Place
Kula, HI 96790
Fax: 1-877-826-1068

Lanai Community Hospital
628 Seventh Street
Lanai City, HI 96763
Fax: 1-808-565-8474

- d. **Request Program Information or Apply by Telephone.** Financial Counselors are available by telephone to provide information, determine FAP eligibility, and assist a patient to apply for FAP. Financial Counselors can be reached at:

Telephone Number(s): 1-808-242-2495, or
1-808-878-1221 or 1-808-565

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

Lanai Community Hospital
628 Seventh Street
Lanai City, HI 96763

- f. **Deliver Completed Application in Person.** Completed applications can be delivered in person to any MH facility.

IV. **Eligibility Criteria.** A patient's household income is considered when determining FAP eligibility. (Refer to section 5.6.1 of the policy)

- a. Means-testing criteria: up to 300% of the Federal Poverty Guidelines

V. **Discount Schedule.** The amounts that MH charges a patient who qualifies for medical financial assistance is based on the type of eligibility criteria used to qualify the patient for the program.



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- a. **Patient Meets Means-testing Criteria.** A patient who meets means-testing criteria will receive a sliding scale discount on the patient cost or portion of charges for services provided for which the patient is responsible. The discount amount is determined by the patient's household income as follows:

Federal Poverty Guidelines Percentages		Financial Assistance Discount
From	To	
0% - 200%		100% Discount
201% - 300%		50% Discount

If a partial discount (less than 100%) is granted, the remaining balance is required to be paid in full or include an option to set up an interest-free payment plan.

- VI. **Basis for Calculating Amounts Generally Billed (AGB).** MH determines AGB for any emergency or other medically necessary care using the look back method by multiplying the gross charges for the care by the AGB rate. Information regarding the AGB rate and calculation is available on the MH website at www.mauihealth.org/patients-and-visitors/billing-information/financial-assistance/.