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1.0 Policy Statement

Kaiser Foundation Health Plans (KFHP) and Kaiser Foundation Hospitals (KFH) are 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 Medical Financial Assistance (MFA) program. 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 MFA 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 and their subsidiaries (collectively referred to as "KFHP/H"):

- 3.1** Kaiser Foundation Health Plan, Inc.
- 3.2** Kaiser Foundation Hospitals; and
- 3.3** KFHP/H subsidiaries.
- 3.4** This policy applies to the Kaiser Foundation Hospitals and hospital-affiliated clinics listed in the attached ADDENDUM, *Section I, Kaiser Foundation Hospitals*, and incorporated herein by reference.

4.0 Definitions

See Appendix A – Glossary of Terms.

5.0 Provisions

KFHP/H maintains a means-tested MFA 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 or not the patient has health coverage.

- 5.1 Services That Are Eligible and Not Eligible Under the MFA Policy.** Unless otherwise noted in the attached ADDENDUM, *Section II, Additional Services Eligible and Not Eligible under the MFA Policy*.

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- 5.1.1 Eligible Services.** MFA may be applied to emergency and medically necessary health care services, pharmacy services and products, and medical supplies provided at Kaiser Permanente (KP) facilities (e.g., hospitals, hospital-affiliated clinics, medical centers, and medical office buildings), at KFHP/H outpatient pharmacies, or by KP providers. MFA 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 KP provider 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.
 - 5.1.1.1.2 Prescriptions and Pharmacy Supplies.** Prescriptions presented at a KFHP/H outpatient pharmacy and written by KP providers, non-KP Emergency Department providers, non-KP Urgent Care providers, and KP contracted providers.
 - 5.1.1.2.1 Generic Medications.** The preferred use of generic medications, whenever possible.
 - 5.1.1.2.2 Brand Medications.** Brand name medications prescribed by a KP provider who notes, "Dispense as Written" (DAW), or no generic equivalent is available.
 - 5.1.1.2.3 Over-the-Counter Drugs or Pharmacy Supplies.** With a prescription or order written by a KP provider and dispensed from a KP outpatient pharmacy.
 - 5.1.1.2.4 Medicare Beneficiaries.** Applied to Medicare beneficiaries for prescription drugs covered under Medicare Part D in the form of a pharmacy waiver.
 - 5.1.1.3 Durable Medical Equipment (DME).** Ordered by a KP provider in accordance with the DME guidelines and supplied by KFHP/H to a patient who meets the medical necessity criteria.
 - 5.1.1.4 Health Education Classes.** Fees associated with available classes scheduled and provided by KP that are recommended by a KP provider as part of the patient's care plan.
 - 5.1.1.5 Services Available on an Exception Basis.** In certain situations that constitute an exception, MFA may be applied to (1) services provided at a non-KP facility and (2) DME prescribed or ordered by a KP provider and supplied by a contracted/vendor as described below. To qualify for the exception, the patient is required to meet the high medical expense criteria described in Section 5.6.2 below.
 - 5.1.1.5.1 Skilled Nursing Services and Intermediate Care Services.** Provided by a contracted KP

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facility to a patient with a prescribed medical need to facilitate inpatient discharge from a hospital.

5.1.1.5.2 Durable Medical Equipment (DME). Vendor supplied DME ordered by a KP provider in accordance with the DME guidelines and supplied by a contracted vendor through the KFHP/H DME Department.

5.1.1.6 Additional Eligible Services Available. Additional services that are eligible under the MFA policy are identified in the attached ADDENDUM, *Section II, Additional Services Eligible and Not Eligible under the MFA Policy.*

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

5.1.2.1 Services that are Not Considered Emergent or Medically Necessary as Determined by a KP Provider. Including, but not limited to:

5.1.2.1.1 Cosmetic surgery or services, including dermatology services that are primarily for the purpose of improving a patient’s appearance,

5.1.2.1.2 Infertility treatments,

5.1.2.1.3 Retail medical supplies,

5.1.2.1.4 Alternative therapies, including acupuncture, chiropractic, and massage services,

5.1.2.1.5 Injections and devices to treat sexual dysfunction,

5.1.2.1.6 Surrogacy services, and

5.1.2.1.7 Services related to third party liability, personal insurance protection or workers’ compensation cases.

5.1.2.1.8 Services for Patients with Non-KP Health Insurance. Non-emergent or non-urgent services and outpatient pharmacy supplies that are covered under the patient’s non-KP health coverage that requires patients to utilize a specified network of preferred non-KP providers and pharmacies.

5.1.2.2 Prescriptions and Pharmacy Supplies. Prescriptions and supplies not considered emergent or medically necessary include, but are not limited to, (1) Drugs that have not been approved by the Pharmacy and Therapeutics Committee, (2) over-the-counter drugs and supplies not prescribed or ordered by a KP provider, and (3) specifically excluded drugs (e.g., fertility, cosmetic, sexual dysfunction).

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5.1.2.3 Prescriptions for Medicare Part D Enrollees Eligible for or Enrolled in Low Income Subsidy (LIS) Program. The remaining cost share for prescription drugs for Medicare Advantage Part D enrollees who are either eligible for or enrolled in the LIS program, in accordance with Centers for Medicare & Medicaid Services (CMS) guidelines.

5.1.2.4 Services Provided Outside of KP Facilities. The MFA policy applies only to services provided at KP facilities, by KP providers. Even upon referral from a KP provider, all other services are ineligible for MFA. Services provided at non-KP medical offices, urgent care facilities and emergency departments, as well as non-KP home health, hospice, recuperative care, and custodial care services, are excluded unless identified as an exception in accordance with Section 5.1.1.5 above.

5.1.2.5 Durable Medical Equipment (DME). Whether or not it is ordered by a KP provider, DME supplied by a contracted vendor is excluded unless identified as an exception in accordance with Section 5.1.1.5 above.

5.1.2.6 Health Plan Premiums. The MFA program does not help patients pay the costs associated with health care coverage (i.e., dues or premiums).

5.1.2.7 Additional Non-Eligible Services. Additional services that are not eligible under the MFA policy are identified in the attached ADDENDUM, *Section II, Additional Services Eligible and Not Eligible under the MFA Policy*.

5.2 Providers. MFA is applied only to eligible services delivered by medical care providers to whom the MFA policy applies, as noted in the attached ADDENDUM, *Section III, Providers Subject to and Not Subject to the MFA Policy*.

5.3 Program Information Sources and How to Apply for MFA. Additional information about the MFA program and how to apply is summarized in the attached ADDENDUM, *Section IV, Program Information and Applying for MFA*.

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

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

5.3.2.1 Screening Patients for Public and Private Program Eligibility. KFHP/H encourages all individuals to obtain health

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insurance coverage for ensuring access to healthcare services, for overall personal health, and for the protection of patient assets. KFHP/H provides financial counseling to patients applying for the MFA program 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 may be required to apply for those programs.

- 5.4 Information Needed to Apply for MFA.** Complete personal, financial, and other information is required to verify a patient’s financial status to determine eligibility for the MFA program, as well as for public and private health coverage programs. MFA 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 the patient applies for assistance. If a patient’s financial status can be verified using external data sources, the patient 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, the patient may be asked to submit the information described in the MFA program application to verify their financial status.
- 5.4.2.1 Complete Information.** MFA program 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 KFHP/H 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 the patient:
- 5.4.2.4.1** Is homeless, or

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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, or

5.4.2.4.3 Has been affected by a well-known national or regional disaster (Refer to Section 5.11 below).

5.4.3 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 taken into account when determining eligibility.

5.5 Presumptive Eligibility Determination. A patient who has not applied may be identified as eligible for the MFA program based on information other than that provided by the patient. If determined to be eligible, the patient is not required to provide personal, financial and other information to verify financial status and may automatically be assigned an MFA award. A patient is presumed to be eligible if the patient has been prequalified or has been identified for bad debt referral, as described below:

5.5.1 Prequalified. A patient who is determined by the financial screening process to qualify for public and private assistance programs is presumed eligible for the MFA program. The patient is considered prequalified if the patient:

5.5.1.1 Is enrolled in a Community MFA (CMFA) 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 KFHP/H sponsored community health event, or

5.5.1.2 Is enrolled in a KP Community Benefit program designed to support access to care for low-income patients and prequalified by designated KFHP/H personnel, or

5.5.1.3 Is enrolled in a credible means-tested health coverage program (e.g., Medicare Low Income Subsidy Program), or

5.5.1.4 Was granted a prior MFA award within the last 30 days

5.5.2 Identified for Bad Debt Referral. After all other eligibility and payment sources have been exhausted, a patient who has received care at a KP facility and there are indications of financial hardship (e.g., past due outstanding balances) may be screened for program eligibility using external data sources. If eligible, the patient receives an MFA award for eligible outstanding balances only. Outstanding balances for qualified services may not be sent to collection, subject to further collection action, or included in KP's bad debt expense.).

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- 5.6 Program Eligibility Criteria.** As summarized in the attached ADDENDUM, *Section V, Eligibility Criteria*, a patient applying for MFA 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.
- 5.6.1.1 Eligibility Based on Income Level.** A patient with a gross household income less than or equal to KFHP/H's means testing criteria as a percentage of the Federal Poverty Guidelines (FPG) is eligible for financial assistance.
- 5.6.1.2 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.
- 5.6.2.1 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 a 12-month period greater than or equal to 10% of annual household income is eligible for financial assistance.
- 5.6.2.1.1 KFHP/H Out-of-Pocket Expenses.** Medical and pharmacy expenses incurred at KP facilities include copayments, deposits, coinsurance, and deductibles related to eligible services.
- 5.6.2.1.2 Non-KFHP/H Out-of-Pocket Expenses.** Medical, pharmacy, and routine dental expenses provided at non-KP 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-KP facilities.
- 5.6.2.1.3 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

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- 5.7.1 Denials.** A patient who applies for the MFA program and does not meet the eligibility criteria is informed either in writing or verbally that his or her request for MFA is denied.
- 5.7.2 How to Appeal an MFA 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 MFA denial letter. Appeals are reviewed by the designated KFHP/H staff.
- 5.8 Award Structure.** MFA awards are applied to past due or outstanding balances identified prior to bad debt referral and pending charges only. MFA awards may also include an eligibility period for any required follow up services as determined by a KP provider.
- 5.8.1 Basis of Award.** The patient cost paid by the MFA program is determined based on whether or not the patient has health care coverage and the patient's household income.
- 5.8.1.1 MFA-Eligible Patient without Health Care Coverage (Uninsured).** An eligible uninsured patient receives a discount on the patient cost of all eligible services.
- 5.8.1.2 MFA-Eligible Patient with Health Care Coverage (Insured).** An eligible insured patient receives a discount on patient cost for all eligible services (1) for which the patient 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 KFHP/H any payments for services provided by KFHP/H which the patient receives from that patient's insurance carrier.
- 5.8.1.3 Discount Schedule.** Additional information about available discounts under the policy are summarized in the attached ADDENDUM, *Section VI, Discount Schedule*.
- 5.8.1.4 Reimbursements from Settlements.** KFHP/H 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 KP in various ways, including:

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- 5.8.2.1 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.
- 5.8.2.2 Skilled Nursing and Intermediate Care.** A maximum of ~~Up to~~ 30 days for services provided outside of KP.
- 5.8.2.3 Durable Medical Equipment.** A maximum of 180 days for vendor supplied medical equipment.
- 5.8.2.4 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 KP provider.
- 5.8.2.5 Patients Who Are Potentially Eligible for Public and Private Health Coverage Programs.** A maximum of 90 days to assist a patient while they apply for public and private health coverage programs.
- 5.8.2.6 One-Time Pharmacy Award.** Prior to applying to the MFA program, a patient is eligible for a one-time pharmacy award if the patient (1) does not have an MFA award, (2) fills a prescription written by a KP provider at a KFHP/H pharmacy, and (3) expresses an inability to pay for the prescription. The one-time award is limited to 30 days and includes a reasonable supply of medication as determined medically appropriate by a KP provider.
- 5.8.2.7 Request for Award Extension.** 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.** KFHP/H may revoke, rescind, or amend an MFA 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 MFA 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 an MFA 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 his or her health coverage or other payment source.

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

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

5.9.1 Amounts Generally Billed. The amounts generally billed (AGB) for emergency or other medically necessary care to individuals who have insurance covering such care are determined for KP facilities as described in the attached ADDENDUM, *Section VII, Basis for Calculating Amounts Generally Billed (AGB)*.

5.10 Collection Actions.

5.10.1 Reasonable Notification Efforts. KFHP/H or a debt collection agency acting on its behalf makes reasonable efforts to notify patients with past due or outstanding balances about the MFA 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 MFA is available for those who qualify.

5.10.1.2 Providing written notice with the list of extraordinary collection actions (ECAs) that KFHP/H 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.

5.10.1.3 Providing a plain language summary of the MFA policy with the first hospital patient statement.

5.10.1.4 Attempting to notify the account holder verbally about the MFA policy and how to obtain assistance through the MFA application process.

5.10.1.5 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. KFHP/H does not conduct or permit collection agencies to conduct on its behalf, extraordinary collection actions (ECAs) against a patient if the patient:

5.10.2.1 Has an active MFA award, or

5.10.2.2 Has initiated an MFA application after ECAs have begun. ECAs are suspended until a final eligibility determination is made.

5.10.3 Allowable Extraordinary Collection Actions.

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5.10.3.1 Final Determination of Reasonable Efforts. Prior to initiating any ECAs, the regional Revenue Cycle Patient Financial Services Leader ensures the following:

5.10.3.1.1 Completion of reasonable efforts to notify the patient of the MFA program, and

5.10.3.1.2 The patient has been provided at least 240 days from the first billing statement to apply for MFA.

5.10.3.2 Reporting to Consumer Credit Agencies or Credit Bureaus. KFHP/H or a debt collection agency acting on its behalf may report adverse information to consumer credit reporting agencies or credit bureaus.

5.10.3.3 Judicial or Civil Actions. Prior to pursuing any judicial or civil actions, KFHP/H validates the patient's financial status using external data sources to determine if the patient is eligible for the MFA program.

5.10.3.3.1 Eligible for MFA. No additional actions are pursued against patients who are eligible for the MFA program. Accounts that qualify for MFA are cancelled and returned on a retrospective basis.

5.10.3.3.2 Not Eligible for MFA. In very limited cases, the following actions may be conducted with prior approval from the regional Chief Financial Officer or Controller:

5.10.3.3.2.1 Garnishment of wages

5.10.3.3.2.2 Lawsuits/civil actions. Legal action is not pursued against an individual who is unemployed and without other significant income.

5.10.3.3.2.3 Liens on residences.

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

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

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

5.10.4.3 Foreclosure on property or seizure of accounts.

5.10.4.4 Request warrants for arrest.

5.10.4.5 Request writs of body attachment.

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5.11 Disaster Response. KFHP/H may temporarily modify its MFA 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 by the state or federal government.

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

5.11.1.1 Suspending eligibility restrictions

5.11.1.2 Increasing the means testing criteria threshold.

5.11.1.3 Decreasing the high medical expense criteria threshold.

5.11.2 Potential Application Process Modifications. Temporary changes to the MFA application process may include:

5.11.2.1 Allowing patients 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 due to the event, and (3) no other evidence exists that may demonstrate eligibility.

5.11.2.2 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 MFA program changes is made available to the public on the MFA program web page and at KP facilities in the affected areas.

6.0 References/Appendices

6.1 Appendix A – Glossary of 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 California Hospital Association – Hospital Financial Assistance Policies & Community Benefit Laws, 2015 Edition

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

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6.3 Provider Lists

6.3.1 Provider lists are available at the KFHP/H websites for:

- 6.3.1.1** Kaiser Permanente of Hawaii
- 6.3.1.2** Kaiser Permanente of Northwest
- 6.3.1.3** Kaiser Permanente of Northern California
- 6.3.1.4** Kaiser Permanente of Southern California
- 6.3.1.5** Kaiser Permanente of Washington

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Appendix A Glossary of Terms

Community MFA (CMFA) refers to 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 refers to a person 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 is 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 are 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 in order to calculate a patient's financial capacity score.

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 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 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.

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**Appendix A
Glossary of Terms (cont.)**

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).

KP Facilities include any physical premises, including the interior and exterior of a building, owned or leased by KP in the conduct of KP business functions, including patient care delivery (e.g., a building, or a KP floor, unit, or other interior or exterior area of a non-KP 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 MFA based on whether the individual's income is greater than a specified percentage of the Federal Poverty Guidelines.

Medical Financial Assistance (MFA) provides monetary 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.

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.

Patient cost means 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 refers to 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 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 the patient 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, similar to an arrest warrant.

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ADDENDUM: Kaiser Permanente Washington

ADDENDUM EFFECTIVE DATE: December 1, 2022

- I. Kaiser Foundation Hospitals Facilities.** This policy applies to all KFHP/H facilities (e.g. hospitals, hospital-affiliated clinics, medical centers and medical office buildings) and outpatient pharmacies. Kaiser Foundation Hospitals in Washington include:
- Kaiser Permanente Central Hospital
- II. Additional Services Eligible and Not Eligible Under the MFA Policy.**
- a. **Additional Eligible Services**
- i. Hearing aids determined to be medically necessary and ordered by a KP provider and purchased through a KP Audiology/Hear Center
 - ii. Optical supplies and hardware determined to be medically necessary and ordered by a KP provider and purchased through KP Eye Care
- b. **Additional Non-Eligible Services**
- i. Emergency and non-emergency transportation
- III. Providers Subject to and Not Subject to the MFA Policy.** The list of providers in KFHP/H facilities that are and are not subject to the MFA policy is available to the general public, without charge, on the KFHP/H MFA website at www.kp.org/mfa/wa.
- IV. Program Information and Applying for MFA.** MFA program information, including copies of the MFA policy, application forms, instructions, and plain language summaries (i.e., program brochures), is available to the general public, without charge, in electronic format or hard copy. A patient can apply for the MFA program, during or following the care received from KFHP/H, in several ways including in person, by telephone, or by paper application. (Refer to Sections 5.3 and 5.4 above.). KFHP/H will assist patient or their guarantors in identifying and applying for available assistance programs including Medicaid and coverage available on the Washington Health Benefit Exchange.
- a. **Complete and Submit Online Application from the KFHP/H Website.** A patient can initiate and submit application information electronically from the MFA website at www.kp.org/mfa/wa.
 - b. **Download Program Information from the KFHP/H Website.** Electronic copies of program information are available on the MFA website at www.kp.org/mfa/wa.

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- c. **Request Program Information Electronically.** Electronic copies of program information are available by email upon request.
- d. **Obtain Program Information or Apply in Person.** Program information is available at the Admitting and Emergency Departments in the Kaiser Foundation Hospitals listed in Section I, *Kaiser Foundation Hospitals*. Staff are also available at the Business Office in each KP urgent care facility. Staff are available at the Business Office or check-in desk at any Kaiser Permanente facility.
- e. **Request Program Information or Apply by Telephone.** Staff are available by telephone to provide information, determine MFA eligibility, and assist a patient to apply for MFA. Staff can be reached from Monday through Friday, 8:00 a.m. to 5:00 p.m., PST at:

Telephone Number(s):
1-800-442-4014 (TTY **711**)

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

Kaiser Permanente MFA Program
PO Box 34584
Seattle, Washington 98124-1584

- g. **Deliver Completed Application In Person.** Completed applications can be delivered in person to any check-in desk or business office at any KP facility.

V. Eligibility Criteria. A patient's household income is considered when determining MFA eligibility. (Refer to Sections 5.6.1. above.). Assets are not considered.

- a. Means Testing Criteria: Up to 300% of the Federal Poverty Guidelines

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VI. Discount Schedule. The amounts that KP 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.

- 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%	250%	75% Discount
251%	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.

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

VII. Basis for Calculating Amounts Generally Billed (AGB). KFHP/H 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 KFHP/H MFA website at www.kp.org/mfa/wa.