Jewish **Senior Living** Group
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Policy Name: Charity Care and Discount Payment Policy	**Policy Owner/Dept**:: CFO/Finance		**Policy Number**: FIN321
Responsible Office: Patient Financial Services Office	**Effective Date**: January 1, 2015		JSLG – Finance
Responsible Official: CFO	**Last Revision**: December 29, 2014		

JEWISH HOME OF SAN FRANCISCO
(INCORPORATED AS HEBREW HOME FOR AGED DISABLED)

I. POLICY BACKGROUND

Jewish Home of San Francisco ("JHSF") offers a Charity Care and Discount Payment Program (the "Program") consistent with the provisions of California Assembly Bill No. 774 (AB 774[1]) as amended by Senate Bill 1276 (SB 1276[2]) and The Federal Affordable Care Act Section 501(r)(4)[3]. It is the policy of JHSF to provide medical care to our patients regardless of their ability to pay.

PURPOSE

The purpose of this policy is to define the criteria which will be used by JHSF to comply with the requirements of the California Hospital Fair Pricing Policies Act.

JHSF will work with patients and their families to explore all available sources and methods of reimbursement for the care JHSF provides, such as private third-party health or liability insurance coverage, government programs such as Medicare, Medi-Cal, Healthy Families, and Sliding Scale, Covered California and charity, discount, and/or extended payment arrangements.

The Program is available to assist patients with limited incomes of up to 350% of the Federal Poverty Level ("FPL"),[4] who are not eligible for coverage under any other state, federal, outpatient, acute or long-term care programs, policies, or plans, including third-party liability coverage such as workers' compensation, auto accident, or homeowner's insurance, or who are underinsured because of "high medical costs" as defined in AB 774. JHSF patients who receive medical services at rates that already are discounted (for whatever reason) are not eligible for the Program.

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[1] AB 774 was codified as California Health and Safety Code sections 127400 through 127446.

[2] SB 1276 fair billing policies; amend Sections 127400, 127420, 127425, 127450, 127454,and 127455 of the Health and Safety Code, relating to health care billing.

[3]Section 501(r), the Internal Revenue Code (Code) by section 9007(a) of the Patient Protection and Affordable Care Act (Affordable Care Act), enacted March 23, 2010, Pub. L. No. 111-14

[4] Federal Poverty Level statistics are published periodically in the Federal Register by the United States Department of Health and Human Services.

In addition to explaining the eligibility criteria for charity care and discount payment, this policy describes the processes for identifying and securing all coverage available through private insurance and government programs, making the Program available to uninsured or underinsured patients, appealing eligibility determinations, and documenting Program-related matters.

It is the intent of this policy to comply with all federal, state, and local laws, including statutes, regulations, ordinances, etc. If any law, current or future, conflicts with this policy, the law will supersede the conflicting provision(s) of this policy.

II. CHARITY CARE

A. Definitions Relating to Charity Care

1. "Charity care" is a term used to describe medically necessary services provided at reduced cost, or no cost, to individuals who are uninsured or underinsured. JHSF patients can receive charity care if they meet all of eligibility requirements described in this policy (which are consistent with AB 774). Charity care will be offered to uninsured and underinsured patients with income levels not exceeding 350% of the FPL, and qualifying assets in accordance with AB 774.

2. A person is "underinsured" for purposes of this policy if that individual meets the following criteria: the patient (a) has a family[5] income that does not exceed 350% of the FPL; (b) does not already receive a discounted rate from JHSF as a result of the patient's insurance coverage or otherwise; and (c) has "high medical costs," defined as either (i) individual out-of-pocket medical costs at JHSF that totaled more than ten percent (10%) of the patient's family income for the past twelve (12) months; or (ii) documented individual out-of-pocket medical costs paid to any healthcare provider(s) in the past twelve (12) months that totaled more than ten percent (10%) of the patient's family income; or (iii) all charges to patients covered by third party insurance, even if those charges include discounted rates as a result of the third-party insurance coverage.

3. To qualify for charity care, a patient's "qualifying assets" must not exceed $250.00 at the time of service, after deducting those assets that cannot be counted under AB 774. According to AB 774, the assets that cannot be counted include the first ten thousand dollars ($10,000.00) of a patient's monetary assets; fifty percent (50%) of a patient's monetary assets over the first ten thousand dollars ($10,000.00); retirement plans; and deferred compensation plans (either qualified under the Internal Revenue Code, or non-qualified). Qualifying assets that can be counted include all of the following: cash; checking accounts; savings accounts; money market funds; certificates of deposit; annuities; and stocks,

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[5] For patients over 18, "family" includes spouse or domestic partner, and dependent children under 21, whether living at home or not. For patients under 18, "family" includes parents or other caretaker relatives, and their other children who are under 21.

bonds or mutual funds that are not part of a retirement or deferred compensation plan (either qualified under the Internal Revenue Code, or non-qualified).

B. Requirements to Apply for Charity Care

1. The patient must comply in a timely manner with JHSF's screening processes by making every reasonable effort to provide full information on all possible forms of coverage, and if the patient asks about charity care, all relevant information about the patient's financial status. Patients who fail to provide necessary information will not be eligible for charity care.

2. The patient must pursue coverage by any third party who might potentially be liable to pay for the patient's care under health insurance, workers' compensation insurance, auto or other liability insurance (*e.g.*, if the patient was injured in a car accident), or other forms of coverage.

3. The patient must apply for government programs for which the patient potentially is eligible, such as Medicare, Medi-Cal, Healthy Families, Sliding Scale, Covered California and other government-funded programs designed to provide health coverage. Patients who do not comply with the requirement to apply for government assistance will not be eligible for charity care/discount payments. However, they may apply for the Flexible Payment Plan.

4. A patient seeking charity care must complete an application and provide required verifications as follows:

   a. most recent three (3) months of patient's pay stubs prior to the date of the application, or

   b. last income tax return;

   c. last three (3) months of all bank statements; and

   d. most recent brokerage account statement(s) or other documentation of the value of stocks, bonds, and/or mutual funds prior to the date of the application, other than those that are part of a retirement or deferred compensation plan.

5. JHSF may require the patient and/or the patient's family to execute waivers or releases authorizing JHSF to obtain account information from financial or commercial institutions, or other entities that hold or maintain monetary assets for the patient, to verify the patient's assets. A patient who declines to provide asset information will be evaluated only for discount payment, not charity care.

C. Charity Care Patient Responsibility for Share of Charges

1. Patients determined to be eligible for charity care who have income levels at or below 100% of the FPL will have no responsibility to pay any portion of the charges for their care at JHSF.

2. Patients determined to be eligible for charity care who have income levels between 100% and 350% of the FPL will receive varying charity care discounts, and will be responsible for paying a specified portion of the charges for their care. The billed charges will not exceed the maximum amount JHSF could receive from any government-sponsored health benefit program for the services provided.[6] Current patient responsibility rates are reflected in Exhibit A to this policy. JHSF reserves the right to change these rates from time to time, in accordance with applicable law.

D. Flexible Payment Plan

If the patient does not meet the requirements for any type of charity care/discount payment, then they may elect to make payment arrangements for their private bill.

If an agreement cannot be reached regarding a payment plan during the negotiation process between the JHSF and the patient, the patient can apply for a Flexible Payment Plan (which is consistent with SB 1276).

The payments are interest-free for low income uninsured patients and certain income-eligible patients with high medical costs.

The patient financial services office will determine the applicant's eligibility for a payment plan based on a review of the patient's family income and monetary assets. The calculated amount is not to exceed 10% of the patient's familial income for one month excluding deductions for "essential living expenses". Essential living expenses are defined as expenses for any of the following:

- rent or house payments (including maintenance expenses),
- food and household supplies, laundry and cleaning expenses

[6] If there is no established government program payment rate for the services provided, JHSF will establish an appropriate discounted payment (per Health and Safety Code section 127405(d)).

- utilities and telephone, clothing,
- medical and dental payments, insurance
- child care, child and spousal support,
- transportation and automobile expenses (including insurance, fuel and repairs),
- installment payments, and other extraordinary expenses

A financial agreement must be signed before the patient financial services office can accept payment arrangements that allow patients to pay their private bills over a period of time.

Once the signed payment plan is in place, the patient must make regular, timely payments. A patient who does not comply will be sent to collections, may have adverse information reported to a consumer credit agency, and may be subject to a property lien, excluding the patient's primary residence. However, asset information obtained in the charity care eligibility determination process will not be used for collection activities. For further information, see JHSF's separate policy regarding debt collection.

III. DISCOUNT PAYMENT

A. Eligibility for Discount Payment

1. Discounts will be offered to uninsured and underinsured (as defined above) patients with income levels not exceeding 350% of the FPL, who choose not to apply for charity care, or who do not qualify for charity care in accordance with the AB 774 criteria described above because of excess qualifying assets.
2. A patient who later applies or is approved for a government program with coverage that does not extend retroactively to the JHSF date of service for the amount owed will not be eligible for charity care, but may apply for discount payment.

B. Requirements to Apply for Discount Payment

1. The patient must comply in a timely manner with JHSF's screening processes by making every reasonable effort to provide full information on all possible forms of coverage, and if the patient asks about charity care or discount payment, all relevant information about the patient's financial status. Patients who fail to provide necessary information will not be eligible for discount payment.

2. The patient must pursue coverage by any third party who might potentially be liable to pay for the patient's care under health insurance, workers' compensation insurance, auto or other liability insurance (*e.g.*, if the patient was injured in a car accident), or other forms of coverage

3. The patient must apply for government programs for which the patient is potentially eligible, such as Medicare, Medi-Cal, Healthy Families, the California Children's Services Program, the San Francisco County Sliding Scale Program, and other government-funded programs designed to provide health coverage. Patients who do not cooperate will not be eligible for discount payment.

4. A patient seeking discount payment must complete an application and provide the required verifications as follows:

    a. most recent three (3) months of patient's pay stubs before the date of the application, or

    b. last income tax return.

C. Discount Payment Patient Responsibility for Share of Charges

Patients determined to be eligible for discount payment will receive varying discounts depending upon their income level, and will be responsible for paying a specified portion of the charges for their care. The billed charges will not exceed the highest amount JHSF could receive from any government-sponsored health benefit program for the services provided.[7] Current patient responsibility rates are reflected in Exhibit A to this policy. JHSF reserves the right to change these rates from time to time, in accordance with applicable law.

IV. PROCEDURE

The Patient Financial Services staff interviews patients and/or their family members or legal representatives to collect demographic, financial, and existing insurance information used in the determination of federal, state, and county program eligibility, as well as other potential coverage.

A. Collection of Existing Coverage and Potential Coverage Information

The Patient Financial Services staff will explore the following potential coverage sources (without limitation), as applicable to the information provided by the patient or his/her representative:

1. Commercial HMO/PPO;

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[7] If there is no established government program payment rate for the services provided, JHSF will establish an appropriate discounted payment, in accordance with Health and Safety Code section 127405(d).

2. Private indemnity insurance

3. Medicare Program

4. Medi-Cal Program

5. Healthy Families Program;

6. Long term care insurance

7. Workers' compensation insurance;

8. Automobile, homeowner's, or other liability insurance; and

9. Self-insured party responsible for patient's injury.

B. Referral of Patients to Government Programs

The Patient Financial Services staff refers patients based on:

1. Provider recommendation;

2. Request from patient, family member, or conservator as a result of information provided;

3. Determination by the Patient Financial Services staff at the time of the registration or admission.

C. Government Program Applications

1. The Patient Financial Services staff assists patients with submitting applications to the Medicare Program, Medi-Cal Program, Covered California, Sliding Scale, Healthy Families Program, or other government programs, as appropriate.

2. The Patient Financial Services staff assists patients to enroll immediately in programs whenever possible.

3. The Patient Financial Services staff identifies and tracks all patients who have pending applications for government programs, and follows up as necessary.

D. Notices

1. Written notice of JHSF's Charity Care and Discount Payment Policy for financially qualified patients will be clearly and conspicuously posted and visible to the public, in the Admissions Office and the Billing Department.

The notice will include information about eligibility, and contact information for the JHSF Patient Financial Services staff, from whom patients and other interested persons can obtain further information about this policy.

2. All private invoices that are mailed monthly to patients will include the following statement;
"*If you are not able to pay the balance in full, please contact the Patient Financial Services Office for payment options*."

3. Written notice including the above information will be given to each patient and will be included in the admission packet.

4. If JHSF bills a patient who has not provided proof of coverage at the time care is provided or upon discharge, JHSF will include with the bill a clear and conspicuous notice that includes all of the following:

   a. a statement of charges for the services rendered;

   b. a request that the patient inform JHSF if the patient has health insurance coverage, Medicare, Healthy Families, Medi-Cal, Sliding Scale, Covered California or other coverage;

   c. a statement that if the patient does not have health insurance coverage, the patient may be eligible for Medicare, Healthy Families, Medi-Cal, California Children's Services Program, or charity care;

   d. a statement of how patients can obtain government program applications and that JHSF will provide such applications; and

   e. information about how financially qualified patients can apply for charity care or discount payment, including the following:

      i. a statement that if the patient lacks or has inadequate insurance, and meets certain low- to moderate-income requirements, the patient may qualify for discount payment or charity care; and

      ii. the name and telephone number of the JHSF Financial Counselor from whom the patient may obtain information about this policy and how to apply.

E. Determination of Eligibility for Charity Care or Discount Payment

1. After making all reasonable efforts to obtain from the patient or the patient's family or representative information about whether private or government health insurance programs or other payers may fully or partially cover the charges for care rendered by JHSF to the patient, the Patient Financial Services staff reviews the patient's information to determine whether the patient has any third-party payers and has completed the eligibility process for all government programs for which the patient may be eligible.

2. To make this determination, Patient Financial Services staff examines third-party insurance information, auto or other liability insurance information, results of personal injury lawsuits, denial notices from government programs, and all other available relevant information.

3. After all possible third-party sources of coverage have been exhausted, if the Patient Financial Services staff determines the patient is self-pay, or insured with high medical costs incurred at JHSF, Patient Financial Services staff provides the patient or the patient's family or representative (as appropriate under the circumstances) with a combined application for charity care and discount payment. The application must be filled out and returned to the Patient Financial Services staff along with all necessary supporting documentation within thirty (30) days.

4. If the Patient Financial Services staff determines that the patient appears to be insured with high medical costs, at least some of which were incurred elsewhere, the Patient Financial Services staff obtains documentation from the patient or the patient's representative to substantiate the patient's out-of-pocket medical costs for the past twelve (12) months. If the Patient Financial Services staff verifies that the patient is financially qualified based on high medical costs, the Patient Financial Services staff provides the patient or the patient's family or representative (as appropriate under the circumstances) with a combined application for charity care and discount payment. The application must be filled out and returned to the Patient Financial Services department along with all necessary supporting documentation within thirty (30) days.

5. The Patient Financial Services staff verifies income with one of the following:

    a. Most recent three (3) months of patient's pay stubs prior to the date of application, or

b. last income tax return.

6. The Patient Financial Services staff verifies assets, for charity care applications only, with the following:

   a. last three (3) months of all bank statements; and

   b. most recent brokerage account statement(s) or other documentation of the value of stocks, bonds, and/or mutual funds prior to the date of the application, other than those that are part of a retirement or deferred compensation plan.

7. If a patient declines to provide assets information, the patient will then be evaluated for discount payment only.

8. The patient has thirty (30) days to provide the completed application and requested verifications (*i.e.* supporting documentation). If the patient fails to provide the completed application and verifications within thirty (30) days, the application is denied.

9. When an application is complete, unless the patient has applied for discount payment only, the Patient Financial Services staff first evaluates the patient's eligibility for charity care. If the patient is ineligible for charity care due to excess assets, the patient is evaluated for discount payment.

10. When an application is complete, the Patient Financial Services staff makes a determination of eligibility according to the AB 774 and SB 1276 criteria set forth in this policy, and notifies the patient.

F. Notification to Patient

1. If the application is approved, the Patient Financial Services staff provides the patient or representative with a copy of the charity care/discount payment determination notice in person or by mail. A copy of the approval notice indicating percentages of discount and patient responsibility will be filed in the Billing Department.

2. If the application is denied, the Patient Financial Services staff documents the reason for the denial and provides the patient or representative with a copy of the document. A copy of the denial notice also is filed in the Billing Department.

G. Notification to Billing Department

1. For an approved application, the Patient Financial Services staff will make the appropriate adjustments on the account.

2. Once the Patient Financial Services Department receives the charity care/discount payment paperwork, the following information is recorded in the Billing Department's charity care log:

   c. patient's name;

   d. hospital registration number;

   e. dates of service;

   f. date the Program application was approved or denied;

   g. admitting service and admitting source; and

   h. if the application was approved, the write-off and patient responsibility percentages.

H. Eligibility Appeals Process

1. The patient or the patient's representative may appeal a denial of a charity care/discount payment application. To do so, the patient must submit a written request to the Jewish Senior Living Group ("JSLG") Chief Financial Officer ("CFO") within fifteen (15) business days of receiving a denial determination.

2. Along with the appeal request, the patient must submit the following items:

   a. a complete copy of the application; and

   b. a statement explaining the reason for requesting review.

3. The CFO reviews the application to determine whether the denial was consistent with this policy, and makes a final decision. The CFO notifies the patient in writing of the final decision.

I. Monitoring and Review Processes

1. When necessary, the Patient Financial Services staff monitors and ensures the following:

a. required notices have been provided to all new patients and are posted where required;

b each patient with an outstanding bill receives a written notice containing all required information, including the name and contact information of the Financial Counselor, and asking the patient to contact the Financial Counselor;

c. government program and charity care/discount payment applications are available on-site; and

d. recently approved and denied charity care/discount payment applications are audited for correctness (except that a denied application need not be audited separately if the patient has appealed to the CFO).

Exhibit A

2014 Poverty Guidelines for the 48 Contiguous States and District of Columbia

Persons in family/household	Gross Yearly Income	Gross Monthly* Income
1	11,670	973
2	15,730	1,311
3	19790	1,650
4	23,850	1,988
5	27,910	2,326
6	31.910	2,659
7	36.030	3,003
8	40,090	3,341
For families/households with more than 8 persons, add $3960 each additional person.		

SOURCE: *Federal Register*, January 22, 2014, (http://aspe.hhs.gov/poverty/12poverty.shtml) *Monthly Income calculated by JSLG & rounded to the nearest dollar

Exhibit B

Partial Assistance Payment Table

Percentage of Poverty Level	**Percentage of patient's responsibly of Charges**
0%-100%	O% of billed charges
101%-125%	15 % of billed charges
126%-175%	30% of billed charges
176%-225%	45% of billed charges
226%-275%	60% of billed charges
276%-325%	75% of billed charges
326%-350%	90% of billed charges